CODE OF VIRGINIA

Title 32.1

Health

Title 32.1 - Health

Chapter 1 - ADMINISTRATION GENERALLY

Article 1 - General Provisions

§ 32.1-1. References to former sections, articles and chapters of Title 32 and other titles.

Whenever any of the conditions, requirements, provisions or contents of any section, article or chapter of Title 32 or any other title of this Code as such titles existed prior to October 1, 1979, are transferred in the same or in modified form to a new section, article or chapter of this title or any other title of this Code and whenever any such former section, article or chapter is given a new number in this or any other title, all references to any such former section, article or chapter of Title 32 or other title appearing in this Code shall be construed to apply to the new or renumbered section, article or chapter containing such conditions, requirements, provisions or contents or portions thereof.

1979, c. 711.

§ 32.1-2. Finding and purpose.

The General Assembly finds that the protection, improvement and preservation of the public health and of the environment are essential to the general welfare of the citizens of the Commonwealth. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health, shall administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and to the environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth.

This comprehensive program of preventive, curative, restorative, and environmental health services shall include prevention and education activities focused on women's health, including, but not limited to, osteoporosis, breast cancer, and other conditions unique to or more prevalent among women.

1979, c. 711; 1995, c. 78.

§ 32.1-3. Definitions.

As used in this title unless the context requires otherwise or it is otherwise provided:

"Board" or "State Board" means the State Board of Health.

"Commissioner" means the State Health Commissioner.

"Department" means the State Department of Health.

"Medical care facility" means any institution, place, building, or agency, whether or not licensed or required to be licensed by the Board or the Department of Behavioral Health and Developmental Services, whether operated for profit or nonprofit, and whether privately owned or privately operated or

owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated, or offered for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition, whether medical or surgical, of two or more nonrelated persons who are injured or physically sick or have mental illness, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, nursing, acute, chronic, convalescent, or long-term care services, or services for individuals with disabilities, or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans.

The term "medical care facility" does not include any facility of (a) the Department of Behavioral Health and Developmental Services; (b) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Behavioral Health and Developmental Services' Comprehensive State Plan; (c) an intermediate care facility for individuals with intellectual disability (ICF/IID) that has no more than 12 beds and is in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services; (d) a physician's office, except that portion of a physician's office described in subdivision A 6 of § 32.1-102.1:3; (e) the Wilson Workforce and Rehabilitation Center of the Department for Aging and Rehabilitative Services; (f) the Department of Corrections; or (g) the Department of Veterans Services.

"Person" means an individual, corporation, partnership, or association or any other legal entity.

1979, c. 711; 2020, c. 1271.

§ 32.1-3.1. Certified mail; subsequent mail or notices may be sent by regular mail.

Whenever in this title the Board, the Commissioner, or the Department is required to send any mail or notice by certified mail and such mail or notice is sent certified mail, return receipt requested, then any subsequent, identical mail or notice that is sent by the Board, the Commissioner, or the Department may be sent by regular mail.

2011, c. 566.

§ 32.1-4. Sovereign immunity.

Nothing contained in this title shall be construed to be a waiver of the defense of sovereign immunity except where expressly provided by the laws of this Commonwealth.

1979, c. 711.

Article 2 - STATE BOARD OF HEALTH

§ 32.1-5. Appointment of members; terms and vacancies.

There shall be a State Board of Health which shall consist of 15 residents of the Commonwealth appointed by the Governor for terms of four years each. Two members of the Board shall be members of the Medical Society of Virginia, one member shall be a member of the Virginia Pharmaceutical Association, one member shall be a member of the State Dental Association, one member shall be a member of the Virginia Nurses' Association, one member shall be a member of the Virginia Veterinary

Medical Association, one member shall be a representative of local government, one member shall be a representative of the hospital industry, one member shall be a representative of the nursing home industry, one member shall be a representative of the licensed health carriers responsible under Title 38.2 for a managed care health insurance plan, one member shall be a corporate purchaser of health care, two members shall be consumers, one member shall have public environmental health expertise, and one member shall be a representative of the emergency medical services community recommended by the State Emergency Medical Services Advisory Board. A vacancy other than by expiration of term shall be filled by the Governor for the unexpired term.

No person shall be eligible to serve more than two full consecutive four-year terms.

Code 1950, § 32-1; 1956, c. 396; 1968, c. 371; 1972, c. 94; 1974, c. 67; 1978, c. 499; 1979, c. 711; 1989, c. 73; 1991, c. 93; 1998, c. 891; 2009, c. 128.

§ 32.1-6. Meetings and chairman.

The Board shall meet annually in the City of Richmond and at such other times and places as it determines. It shall elect from its number a chairman who shall perform the usual duties of such officer in addition to the particular duties prescribed by law.

Code 1950, § 32-2; 1979, c. 711.

§ 32.1-7. Bylaws.

The Board may adopt bylaws for its operation.

Code 1950, § 32-3; 1979, c. 711.

§ 32.1-8. Quorum.

Six members of the Board shall constitute a quorum for the transaction of any lawful business.

Code 1950, § 32-4; 1974, c. 436; 1979, c. 711; 1989, c. 73.

§ 32.1-9. Secretary.

The Commissioner or, with the approval of the Board, his designee shall act as secretary of the Board and shall not be entitled to any additional compensation for such service.

Code 1950, § 32-5; 1979, c. 711.

§ 32.1-10. Repealed.

Repealed by Acts 1980, c. 728.

§ 32.1-11. Environmental health, laboratory, and medical care services.

A. The Board may formulate a program of environmental health services, laboratory services and preventive, curative and restorative medical care services, including home and clinic health services described in Titles V, XVIII and XIX of the United States Social Security Act and amendments thereto, to be provided by the Department on a regional, district or local basis.

B. The Board shall define the income limitations within which a person shall be deemed to be medically indigent. Persons so deemed to be medically indigent shall receive the medical care services of

the Department without charge. The Board may also prescribe the charges to be paid for the medical care services of the Department by persons who are not deemed to be medically indigent and may, in its discretion and within the limitations of available funds, prescribe a scale of such charges based upon ability to pay. Funds received in payment of such charges are hereby appropriated to the Board for the purpose of carrying out the provisions of this title.

C. When the Department provides medical care services to a person who has private health insurance that covers the services provided, the Board shall authorize the Department to charge an amount equal to the allowable charge of such insurer for the services provided. If the insurer denies a claim for medical care services provided to such person, the patient portion of the bill shall not be greater than if the person did not have private health insurance.

D. The Board shall review periodically the program and charges adopted pursuant to this section.

Code 1950, § 32-8.1; 1966, c. 529; 1970, c. 439; 1979, c. 711; 2008, cc. 42, 81.

§ 32.1-11.1. Board to establish acquired immunodeficiency syndrome services and education grants program.

With such funds as are appropriated for this purpose, the Board of Health shall establish the acquired immunodeficiency syndrome services and education grants program. The Board may award grants for (i) the provision of direct patient services including, but not limited to, mental health services, and home and community based health services; and (ii) broad-based community AIDS education efforts including, but not limited to, education of high risk populations, street outreach efforts and improvement of public knowledge, awareness and attitudes about human immunodeficiency virus infection and persons with acquired immunodeficiency syndrome.

The State Department of Health shall seek the advice of experts in the delivery of services to persons with AIDS and AIDS education to assist in the administration of the grants program.

1989, c. 613; 2003, c. 453.

§ 32.1-11.2. Regional AIDS resource and consultation centers; HIV early intervention centers.

Utilizing existing state and local facilities and from such funds as are appropriated for this purpose, the Board of Health shall provide grants for no more than five regional AIDS resource and consultation centers and four HIV early intervention centers.

Each regional AIDS resource and consultation center shall be designed to address the need for expanded medical care and support services for persons with human immunodeficiency virus infection through education of health care professionals on a broad range of AIDS-related issues, clinical training for health care practitioners and students, medical consultation to community physicians and other health care providers, provision of current technical medical materials such as manuals and protocols for the management of HIV infection and medical literature, facilitation of access to health services, mental health and substance abuse services, support services and case management for HIV-infected persons. The regional AIDS resource and consultation centers shall cooperate with at least one of the medical schools located in the Commonwealth.

Each HIV early intervention center shall supply medical care and support services for persons with human immunodeficiency virus infection in accordance with its agreement with the Commissioner of Health.

The Board shall establish criteria for award of the grants. The criteria for the grants for the regional AIDS resource and consultation centers shall include, but not be limited to: (i) priority targeting of funds for services to high risk populations; (ii) geographical distribution of the centers in order to provide equal access to services throughout the Commonwealth; (iii) pro rata apportionment of funds according to the number of cases of acquired immunodeficiency syndrome in the various areas of the Commonwealth; (iv) development of innovative and flexible approaches to provision of services tailored to the specific needs of patients in the region; and (v) extensive community involvement.

1989, c. 613; 1993, c. 664; 1994, c. 610.

§ 32.1-11.3. Patient and community health education services.

The Board shall formulate a program of patient and community health education services to be provided by the Department on a regional, district, or local basis. The program shall include services addressing health promotion and disease prevention and shall encourage the coordination of local and private sector health education services. This program shall include information on the causes, prevention, early detection, and treatment of osteoporosis.

1991, c. 195; 1995, c. 78.

§ 32.1-11.4. Repealed.

Repealed by Acts 2007, c. 4, cl. 1.

§ 32.1-11.5. Repealed.

Repealed by Acts 2016, c. 495, cl. 2.

§ 32.1-11.6. Virginia Pregnant Women Support Fund; purpose; guidelines.

A. There is hereby created the Virginia Pregnant Women Support Fund (the Fund) as a special non-reverting fund to be administered by the Board of Health to support women and families who are facing unplanned pregnancy.

B. The Board of Health shall have authority to solicit and accept gifts, donations, and bequests and to apply for grants on behalf of the Fund from any source and to deposit all moneys received in the Fund. The Council shall submit to the Governor an annual report of all gifts, donations, grants and bequests accepted; the names of the donors; and the respective amounts contributed by each donor.

C. The Fund shall be established on the books of the Comptroller. All moneys received from any source pursuant to subsection B shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of carrying out the activities enumerated below:

1. Purchasing or upgrading ultrasound equipment;

2. Creating a separate program for domestic violence, dating violence, sexual assault and stalking screening against pregnant women and new mothers;

3. Conducting a public campaign to increase public awareness;

4. Providing support services for students of institutions of higher education;

5. Providing funds to allow early childhood education programs to work with pregnant or parenting teens to complete high school and provide job training education; or

6. Providing for teenage or first-time mothers education on the health needs of their infants through free home visits by registered nurses.

D. The Board of Health shall establish an application process and related procedures for community health centers, migrant health centers, homeless health centers, and public-housing centers seeking grants from the Fund. A grant may be made only if an application for the grant is submitted to the Board of Health and the application is in such a form, is made in such a manner, and contains such agreements, assurances, and information as the Board determines to be necessary to carry out its functions.

2007, cc. 780, 822.

§ 32.1-11.7. Guidelines for cleanup of residential property used to manufacture methamphetamine.
The Board, in consultation with the Department of Environmental Quality and other relevant entities, shall establish guidelines for the cleanup of residential property and other buildings formerly used as sites to manufacture methamphetamine to certify that the methamphetamine level at such property is at or below the post cleanup target.

2012, c. 778; 2013, c. 557; 2014, c. 513.

§ 32.1-12. Regulations, variances and exemptions.
The Board may make, adopt, promulgate and enforce such regulations and provide for reasonable variances and exemptions therefrom as may be necessary to carry out the provisions of this title and other laws of the Commonwealth administered by it, the Commissioner or the Department.

Code 1950, § 32-6; 1972, c. 504; 1979, c. 711.

§ 32.1-12.1. Board to establish regulations regarding human research.
The Board shall promulgate regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) to effectuate the provisions of Chapter 5.1 (§ 32.1-162.16 et seq.) of this title for human research, as defined in § 32.1-162.16, to be conducted or authorized by the Department or any facilities or other entities operated, funded, or licensed by the Department. The regulations shall require the human research committee to submit to the Governor, the General Assembly, and the Commissioner or his designee at least annually a report on the human research projects reviewed and approved by the

committee and shall require the committee to report any significant deviations from the proposals as approved.

1992, c. 603.

§ 32.1-13. Emergency orders and regulations.

The Board may make separate orders and regulations to meet any emergency, not provided for by general regulations, for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious and infectious diseases and other dangers to the public life and health.

Code 1950, § 32-12; 1979, c. 711.

§ 32.1-13.1. Health policy responsibilities.

The Board of Health may direct the Department to inform it regarding health care policy and financing concerns through such studies as the Board may deem necessary and appropriate to be conducted. The Board may make recommendations concerning health care policy to the Governor, the General Assembly, and the Secretary of Health and Human Resources.

1989, c. 73; 2002, c. 83.

§ 32.1-14. Annual report.

The Board shall submit an annual report to the Governor and General Assembly. Such report shall contain information on the Commonwealth's vital records and health statistics and an analysis and summary of health care issues affecting the citizens of Virginia, including but not limited to, health status indicators, the effectiveness of delivery of health care, progress toward meeting standards and goals, the financial and geographic accessibility of health care, and the distribution of health care resources, with particular attention to health care access for those Virginia citizens in rural areas, inner cities, and with greatest economic need. Such report shall also contain statistics and analysis regarding the health status and conditions of minority populations in the Commonwealth by age, gender, and locality.

Code 1950, §§ 32-20, 32-30; 1979, c. 711; 1984, c. 734; 1989, c. 73; 1999, c. 579; 2004, c. 650.

§ 32.1-15. Suggestions as to legislation.

The Board may, at each regular session of the General Assembly, suggest any legislative action deemed necessary for the better protection of life and public health.

Code 1950, § 32-21; 1979, c. 711.

§ 32.1-15.1. Certified community health workers.

A. As used in this section, "certified community health worker" means a community health worker who has met the requirements of subsection B.

B. No person shall use or assume the title "certified community health worker" unless he is a community health worker who (i) has received training and education as a community health worker from an entity approved by a body approved by the Board and (ii) is certified as a certified community health worker by a body approved by the Board.

C. No entity shall hold itself out as providing training and education for certified community health workers required by subsection B unless its curriculum and training program has been approved by a body approved by the Board.

D. The Board shall adopt regulations setting forth requirements for (i) use of the title "certified community health worker" and (ii) education and training programs necessary to meet the requirements for certification as a certified community health worker.

2020, c. 363.

Article 3 - DEPARTMENT OF HEALTH AND STATE HEALTH COMMISSIONER

§ 32.1-16. State Department of Health.

A. There shall be a State Department of Health in the executive department responsible to the Secretary of Health and Human Resources. The Department shall be under the supervision and management of the State Health Commissioner. The Commissioner shall carry out his management and supervisory responsibilities in accordance with the policies, rules and regulations of the Board.

B. In addition to other duties imposed on the Department pursuant to this title, the Department shall assist in the plan management functions of the federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth, including providing assistance to the State Corporation Commission in its performance of plan management functions as set forth in § 38.2-326. The Department shall be compensated for expenses incurred in providing such services.

1979, c. 711; 2013, cc. 670, 679.

§ 32.1-17. Appointment of Commissioner; qualifications; term.

A. There shall be a State Health Commissioner appointed by the Governor, subject to confirmation by each house of the General Assembly. The Commissioner shall be a physician licensed to practice medicine in this Commonwealth and shall be certified by the American Board of Preventive Medicine or a recognized board in a primary care specialty as approved by the American Board of Medical Specialties, experienced in public health duties, sanitary science and environmental health, and otherwise qualified to execute the duties incumbent upon him by law.

B. The Commissioner shall be appointed for a term coincident with that of the Governor and shall serve at the pleasure of the Governor.

Code 1950, §§ 32-23, 32-25; 1979, c. 711; 2000, c. 168.

§ 32.1-18. Executive officer of Board.

The Commissioner shall be the executive officer of the Board but shall not be a member thereof.

Code 1950, § 32-24; 1979, c. 711.

§ 32.1-19. Duties prescribed by Board.

A. The Commissioner shall perform such duties as the Board may require, in addition to the duties required by law.

B. The Commissioner shall, along with the Superintendent of Public Instruction, work to combat childhood obesity and other chronic health conditions that affect school-age children.

C. The Commissioner shall ensure, in the licensure of health care facilities, that quality of care, patient safety, and patient privacy are the overriding goals of such licensure and related enforcement efforts.

D. The Commissioner shall coordinate the Department's emergency preparedness and response efforts.

E. The Commissioner shall ensure that prevention of disease and protection of public health remain the Department's overriding goals.

F. The Commissioner shall designate a senior staff member of the Department, who shall be a licensed physician, to oversee minority health efforts of the Department.

G. The Commissioner shall designate a senior official of the Department, who shall be a licensed physician or an advanced practice registered nurse, to coordinate all women's health efforts in the Department including, but not limited to, the "Every Woman's Life Program," and other efforts to prevent, detect, and treat breast cancer, cervical cancer, and other diseases that primarily affect women.

Code 1950, § 32-27; 1979, c. 711; 2007, cc. 43, 55, 320, 343, 793, 797; 2023, c. 183.

§ 32.1-19.1. Repealed.

Repealed by Acts 2004, c. 683.

§ 32.1-20. Vested with authority of Board.

The Commissioner shall be vested with all the authority of the Board when it is not in session, subject to such rules and regulations as may be prescribed by the Board.

Code 1950, § 32-28; 1979, c. 711.

§ 32.1-21. Salary; teaching activities.

The Commissioner shall receive such salary as is fixed by law and shall devote his entire time to his official duties; provided, however, that the Board, with the approval of the Governor, may authorize the Commissioner to accept or undertake teaching activities.

Code 1950, § 32-26; 1979, c. 711.

§ 32.1-22. Personnel; Deputy Commissioner.

A. The Commissioner may employ such personnel as are necessary for the proper performance of his duties as executive officer of the Board.

B. The Commissioner, subject to the approval of the Board, may appoint a Deputy Commissioner of Health who shall meet the qualifications for appointment as Commissioner and who may exercise the powers and perform the duties of the Commissioner in the case of the absence or inability to act of the Commissioner.

Code 1950, § 32-31; 1979, c. 711.

§ 32.1-23. Publication of information.

A. The Commissioner may provide for the publication and distribution of such information as may contribute to the preservation of the public health and the prevention of disease.

B. The Commissioner shall establish, maintain and publicize a toll-free number to provide resource and referral information on pharmaceutical companies' free and discount drug programs for persons who demonstrate financial hardship or otherwise meet program eligibility criteria. Such information shall include, but not be limited to, available drugs, participating pharmaceutical companies, and application procedures for each of the pharmaceutical companies and dispensing methods. Such information shall also include the locations of various Pharmacy Connect programs accessible by that person. The Commissioner may contract with one or more public or private organizations to administer this resource and referral program.

Code 1950, § 32-11; 1979, c. 711; 2001, c. 823; 2002, c. 896.

§ 32.1-23.01. Information about and resources on palliative care.

The Department shall make information about and resources on palliative care available to the public, health care providers, and health care facilities on its website. Such information shall include information about the delivery of palliative care in the home and in primary, secondary, and tertiary environments; best practices for the delivery of palliative care; consumer education materials and referral information for palliative care; and continuing education opportunities for health care providers.

2017, cc. 471, 746.

§ 32.1-23.1. Alternative delivery of certain information; Commissioners to develop single application form for pharmaceutical assistance programs and pharmaceutical discount purchasing cards; certain analysis of access to The Pharmacy Connection program.

A. The Commissioner shall create links from the Virginia Department of Health's website to the Virginia Department for Aging and Rehabilitative Services' website and its affiliated sites pertaining to pharmaceutical assistance programs and pharmaceutical discount purchasing cards. The Commissioner for Aging and Rehabilitative Services shall cooperate with the Commissioner of Health by ensuring that such information is available on the Department for Aging and Rehabilitative Services' website.

B. The Commissioner shall ensure that all clinical sites administered by local health departments are provided with adequate information concerning the services of the Virginia Department for Aging and Rehabilitative Services, including, but not limited to, its toll-free telephone number and its website information on pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

C. The Commissioner of Health and the Commissioner for Aging and Rehabilitative Services shall coordinate the dissemination of information to the public regarding any pharmaceutical discount purchasing card programs while maintaining a neutral posture regarding such programs.

In addition, with such funds as may be made available, the Commissioner of Health and the Commissioner for Aging and Rehabilitative Services shall disseminate information to the public concerning recent congressional actions relating to pharmaceutical benefits to be provided under the Medicare program and how such benefits may help senior citizens with the costs of pharmaceutical benefits.

D. The Commissioner shall establish a toll-free telephone number, to be administered by the Virginia Department of Health, which shall provide recorded information concerning services available from the Department for Aging and Rehabilitative Services, the Virginia Association of Area Agencies on Aging, and other appropriate organizations for senior citizens.

E. The Commissioner of Health and the Commissioner for Aging and Rehabilitative Services shall develop a strategy, in coordination with the Virginia Association of Area Agencies on Aging and other private and nonprofit organizations, for disseminating information to the public concerning the availability of pharmaceutical assistance programs and for training senior citizen volunteers to assist in completing applications for pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

F. In addition to the responsibilities set forth in subsections A through E, the Commissioner of Health and the Commissioner for Aging and Rehabilitative Services shall encourage pharmaceutical manufacturers to include application forms for pharmaceutical discount purchasing card programs on their respective websites in a format capable of being downloaded and printed by consumers. When practicable, the website maintained by the Department for Aging and Rehabilitative Services shall include direct links to such forms. Further, the Commissioner of Health and the Commissioner for Aging and Rehabilitative Services shall report to the Governor and General Assembly by October 30, 2004, on the feasibility of developing a single application form for Virginians to use to seek eligibility for the nearly 50 pharmaceutical assistance programs and pharmaceutical discount purchasing cards.

In determining feasibility, the Commissioners shall obtain copies of the application forms used by such pharmaceutical assistance programs and pharmaceutical discount purchasing cards in Virginia, compile a list of the various information required to complete such application forms, identify common elements, and analyze the forms for readability and simplicity. Upon completion of this analysis, the Commissioners shall assess the feasibility of designing a single, concise application form that is logically formatted, written in clear and easily comprehensible language, and covers any and all data that may be required to obtain eligibility for any such pharmaceutical assistance program or pharmaceutical discount purchasing card.

G. In order to maximize the benefits of the new Medicare pharmaceutical discount card program for Virginia's senior citizens, the Commissioner of Health shall annually for two years commencing on July 1, 2005, (i) analyze access to The Pharmacy Connection program vis-a-vis the Medicare pharmaceutical discount card program, the $600 transitional coverage provided under federal law, and pharmaceutical companies' offers of "wrap-around" coverage for low-income seniors; and (ii)

recommend, to the Virginia Health Care Foundation, the Secretary of Health and Human Resources, and the Governor, appropriate localities for expansion of access to The Pharmacy Connection program in Virginia, particularly in areas having high concentrations of low-income seniors. The goal of the Commissioner's analysis shall be to facilitate statewide implementation of The Pharmacy Connection program. The Commissioner shall complete this analysis by October 31 of each year and shall immediately request an estimate of the costs of the recommended expansion of such access from the Virginia Health Care Foundation to be forwarded to the Secretary and the Governor, for inclusion in the appropriation act, in so far as possible and appropriate to promote the health and safety of Virginia's senior citizens.

H. To assist them in completing the responsibilities set forth in subsections E, F, and G, the Commissioners may appoint an advisory task force of stakeholders.

2003, cc. 661, 674; 2004, cc. 73, 318; 2005, c. 715; 2012, cc. 803, 835.

§ 32.1-23.2. Sexual assault nurse examiner information.

A. The Department shall develop and make available on a website maintained by the Department information about the availability of certified sexual assault nurse examiners in the Commonwealth. Such information shall include the name of the hospital at which a certified sexual assault nurse examiner is employed; the location, including street address, of the hospital; and the contact information for the hospital. A link to the information shall be prominently displayed on the Department's website, and such information shall be made available in a format that is easily accessible to and navigable by members of the public.

B. Every hospital licensed by the Department shall quarterly report to the Department, in a form and by such date as shall be designated by the Department, the total number of certified sexual assault advanced practice registered nurses employed by the hospital and the location, including street address, and contact information for each location at which such certified sexual assault advanced practice registered nurse provides services.

2020, c. 1088; 2023, c. 183.

§ 32.1-23.3. Eligible Health Care Provider Reserve Directory.

A. As used in this section, "eligible health care provider" means (i) any person licensed, registered, or certified by a health regulatory board within the Department of Health Professions whose license, registration, or certification is in good standing, or was in good standing within five years or less prior and only lapsed because such person retired; (ii) any emergency medical services provider certified or licensed by the Department of Health whose certification or licensing is in good standing, or was in good standing within five years or less prior and only lapsed because such person retired; and (iii) any fourth-year medical student who is engaged in a course of study approved by the Board of Medicine and is in good standing with the student's medical school and is scheduled to graduate early or on time who registers for the Eligible Health Care Provider Reserve Directory (the Directory).

B. The Department shall establish an Eligible Health Care Provider Reserve Directory to collect information regarding eligible health care providers in the Commonwealth who are qualified and who may be available to assist in the response to a public health emergency. The Directory shall include the name, contact information, and licensure, certification, or registration type and status of the eligible health care provider or, if the eligible health care provider is a fourth-year medical student, academic standing and anticipated graduation date of the fourth-year medical student. Every health regulatory board of the Department of Health Professions, the Office of Emergency Medical Services of the Department of Health, and each medical school located in the Commonwealth, upon the request of a fourth-year medical student, shall provide such information to the Department for inclusion in the Directory.

C. During a declared public health emergency, the Governor may request and the Commissioner may provide information regarding eligible health care providers from the Directory. Information obtained from the Directory may be used to (i) identify eligible health care providers who may be able to assist in responding to the public health emergency and (ii) contact such eligible health care providers to request assistance in responding to the public health emergency. Information contained in the Directory shall not be used for any other purpose.

2021, Sp. Sess. I, c. 530.

§ 32.1-23.4. Prescription drug price transparency; civil penalty.

A. As used in this section, "nonprofit data services organization" means the nonprofit organization with which the Commissioner has negotiated and entered into a contract or agreement for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to § 32.1-276.4.

B. The Department shall negotiate and enter into a contract or agreement with a nonprofit data services organization to annually collect, compile, and make available on its website publicly available information about prescription drug prices submitted by health carriers and pharmacy benefits managers pursuant to § 38.2-3407.15:6, wholesale distributors pursuant to § 54.1-3436.1, and manufacturers pursuant to § 54.1-3442.02. Such data and information shall be made available in aggregate in a form and manner that does not disclose or tend to disclose proprietary or confidential information of any health carrier, pharmacy benefits manager, wholesale distributor, or manufacturer.

C. A health carrier, pharmacy benefits manager, wholesale distributor, or manufacturer that fails to report information required to be reported pursuant to this section or § 38.2-3407.15:6, 54.1-3436.1, or 54.1-3442.02, respectively, shall be subject to a civil penalty not to exceed $2,500 per day from the date on which such reporting is required, to be collected by the Commissioner and deposited into the Literary Fund. However, the Commissioner may reduce or waive a civil penalty imposed pursuant to this section if he determines that the violation was reasonable or resulting from good cause.

D. The Department shall adopt regulations to implement the provisions of this section, which shall include (i) provisions related to the specification of prescription drugs for the purpose of data collection and procedures for auditing information provided by health carriers, pharmacy benefits managers,

wholesale distributors, and manufacturers and (ii) a schedule of civil penalties for failure to report information required pursuant to this section or § 38.2-3407.15:6, 54.1-3436.1, or 54.1-3442.02, which shall be based on the level of severity of the violation.

E. All information submitted by a health carrier or pharmacy benefits manager pursuant to § 38.2-3407.15:6, a wholesale distributor pursuant to § 54.1-3436.1, or a manufacturer pursuant to § 54.1-3442.02 shall be confidential and exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), except to the extent that such information is included in an aggregated form in the report required pursuant to this section.

2021, Sp. Sess. I, c. 304.

§ 32.1-23.5. Reporting of certain data regarding financial assistance.

The Commissioner shall report annually by November 1 to the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Appropriations and Education and Health regarding data collected pursuant to subsection F of § 32.1-276.5, including the value of (i) the amount of charity care, discounted care, or other financial assistance provided by each hospital under its financial assistance policy that is required to be reported in accordance with subsection F of § 32.1-276.5 and (ii) the amount of uncollected bad debt, including any uncollected bad debt from payment plans entered into in accordance with subsection C of § 32.1-137.09.

2022, cc. 678, 679.

§ 32.1-23.6. Information and data related to social determinants of health.

A. As used in this section:

"Demographic data" means data and information regarding the race, ethnicity, age, and gender of residents of the Commonwealth.

"Social determinants of health" means conditions that affect health risks and health outcomes, including health care access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment.

B. The Department shall (i) collect and analyze information regarding demographics and the social determinants of health and their impacts on health and health risks of residents of the Commonwealth and (ii) make such information and analyses available to the public on its website. Nothing in this section shall allow for the release of personal health information or any other confidential information.

2022, c. 750.

Article 4 - PROCEDURES; INSPECTIONS; ORDERS; PENALTIES; REPRESENTATION BY ATTORNEY GENERAL

§ 32.1-24. Applicability of Administrative Process Act.

The provisions of the Administrative Process Act (§ 2.2-4000 et seq.) shall govern the procedures for rendering all case decisions, as defined in § 2.2-4001, and issuing all orders and regulations under the provisions of this Code administered by the Board, the Commissioner or the Department unless exempt from the Administrative Process Act.

1979, c. 711.

§ 32.1-25. Right of entry to inspect, etc.; warrants.

Upon presentation of appropriate credentials and upon consent of the owner or custodian, the Commissioner or his designee shall have the right to enter at any reasonable time onto any property to inspect, investigate, evaluate, conduct tests or take samples for testing as he reasonably deems necessary in order to determine compliance with the provisions of any law administered by the Board, Commissioner or Department, any regulations of the Board, any order of the Board or Commissioner or any conditions in a permit, license or certificate issued by the Board or Commissioner. This right of entry shall not apply to privileged communications pursuant to § 8.01-581.17. If the Commissioner or his designee is denied entry, he may apply to an appropriate circuit court for an inspection warrant authorizing such investigation, evaluation, inspection, testing or taking of samples for testing as provided in Chapter 24 (§ 19.2-393 et seq.) of Title 19.2.

1979, c. 711; 1998, c. 772.

§ 32.1-26. Orders; hearing and notice.

The Board is authorized to issue orders to require any person to comply with the provisions of any law administered by it, the Commissioner or the Department or any regulations promulgated by the Board or to comply with any case decision, as defined in § 2.2-4001, of the Board or Commissioner. Any such order shall be issued only after a hearing with at least thirty days' notice to the affected person of the time, place and purpose thereof. Such order shall become effective not less than fifteen days after mailing a copy thereof by certified mail to the last known address of such person. The provisions of this section shall not affect the authority of the Board to issue separate orders and regulations to meet any emergency as provided in § 32.1-13.

1979, c. 711.

§ 32.1-27. Penalties, injunctions, civil penalties and charges for violations.

A. Any person willfully violating or refusing, failing or neglecting to comply with any regulation or order of the Board or Commissioner or any provision of this title shall be guilty of a Class 1 misdemeanor unless a different penalty is specified.

B. Any person violating or failing, neglecting, or refusing to obey any lawful regulation or order of the Board or Commissioner or any provision of this title may be compelled in a proceeding instituted in an appropriate court by the Board or Commissioner to obey such regulation, order or provision of this title and to comply therewith by injunction, mandamus, or other appropriate remedy or, pursuant to § 32.1-27.1, imposition of a civil penalty or appointment of a receiver.

C. Without limiting the remedies which may be obtained in subsection B of this section, any person violating or failing, neglecting or refusing to obey any injunction, mandamus or other remedy obtained pursuant to subsection B shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation, which shall be paid to the general fund, except that civil penalties for environmental pollution shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2. Each day of violation shall constitute a separate offense.

D. With the consent of any person who has violated or failed, neglected or refused to obey any regulation or order of the Board or Commissioner or any provision of this title, the Board may provide, in an order issued by the Board against such person, for the payment of civil charges for past violations in specific sums, not to exceed the limits specified in § 32.1-27.1 and subsection C of this section. Such civil charges shall be instead of any appropriate civil penalty which could be imposed under § 32.1-27.1 and subsection C of this section. When civil charges are based upon environmental pollution, the civil charges shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2.

Code 1950, §§ 32-6.4, 32-15; 1975, c. 564; 1976, c. 623; 1979, c. 711; 1980, c. 378; 1989, c. 618; 1999, c. 786; 2003, cc. 753, 762.

§ 32.1-27.1. (Effective until July 1, 2025) Additional civil penalty or appointment of a receiver.
A. In addition to the remedies provided in § 32.1-27, the civil penalties set forth in this section may be imposed by the circuit court for the city or county in which the facility is located as follows:

1. A civil penalty for a Class I violation shall not exceed the lesser of $25 per licensed or certified bed or $1,000 for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

2. A civil penalty for a Class II violation shall not exceed the lesser of $5 per licensed or certified bed or $250 per day for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

In the event federal law or regulations require a civil penalty in excess of the amounts set forth above for Class I or Class II violations, then the lowest amounts required by such federal law or regulations shall become the maximum civil penalties under this section. The date of notification under this section shall be deemed to be the date of receipt by the facility of written notice of the alleged Class I or Class II violation, which notice shall include specifics of the violation charged and which notice shall be hand delivered or sent by overnight express mail or by registered or certified mail, return receipt requested.

All civil penalties received pursuant to this subsection shall be paid into a special fund of the Department for the cost of implementation of this section, to be applied to the protection of the health or property of residents or patients of facilities that the Commissioner or the United States Secretary of Health and Human Services finds in violation, including payment for the costs for relocation of patients, main-

tenance of temporary management or receivership to operate a facility pending correction of a violation, and for reimbursement to residents or patients of lost personal funds.

B. In addition to the remedies provided in § 32.1-27 and the civil penalties set forth in subsection A of this section, the Commissioner may petition the circuit court for the jurisdiction in which any nursing home or certified nursing facility as defined in § 32.1-123 is located for the appointment of a receiver in accordance with the provisions of this subsection whenever such nursing home or certified nursing facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked or suspended, or that its Medicare or Medicaid certification has been or will be cancelled or revoked; or (ii) receive official notice from the United States Department of Health and Human Services or the Department of Medical Assistance Services that its provider agreement has been or will be revoked, cancelled, terminated or not renewed; or (iii) advise the Department of its intention to close or not to renew its license or Medicare or Medicaid provider agreement less than ninety days in advance; or (iv) operate at any time under conditions which present a major and continuing threat to the health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (v) the Department is unable to make adequate and timely arrangements for relocating all patients who are receiving medical assistance under this chapter and Title XIX of the Social Security Act in order to ensure their continued safety and health care.

Upon the filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iv) above to exist in combination with the condition identified in (v) and the court further finds that such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receivership established under this subsection shall continue in effect for more than 180 days without further order of the court, nor shall the receivership continue in effect following the revocation of the nursing home's license or the termination of the certified nursing facility's Medicare or Medicaid provider agreement, except to enforce any post-termination duties of the provider as required by the provisions of the Medicare or Medicaid provider agreement.

The appointed receiver shall be a person licensed as nursing home administrator in the Commonwealth pursuant to Title 54.1 or, if not so licensed, shall employ and supervise a person so licensed to administer the day-to-day business of the nursing home or certified nursing facility.

The receiver shall have (i) such powers and duties to manage the nursing home or certified nursing facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new patients during the receivership, (ii) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments

on behalf of the owner or operator of the nursing home or certified nursing facility, (iii) the power to execute and avoid executory contracts, (iv) the power to hire and discharge employees, and (v) the power to do all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have been substantially eliminated or remedied, or (ii) all patients in the nursing home or certified nursing facility have been relocated. Within thirty days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the nursing home or certified nursing facility from Medicare, Medicaid and other patient care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the nursing home or certified nursing facility which existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts which result in injuries to persons or damage to property at the nursing home or certified nursing facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or of any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

1989, c. 618; 1996, cc. 788, 797.

§ 32.1-27.1. (Effective July 1, 2025) Additional civil penalty or appointment of a receiver.

A. In addition to the remedies provided in §§ 32.1-27 and 32.1-27.2, the civil penalties set forth in this section may be imposed by the circuit court for the city or county in which the facility is located as follows:

1. A civil penalty for a Class I violation shall not exceed the lesser of $25 per licensed or certified bed or $1,000 for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

2. A civil penalty for a Class II violation shall not exceed the lesser of $5 per licensed or certified bed or $250 per day for each day the facility is in violation, beginning on the date the facility was first notified of the violation.

In the event federal law or regulations require a civil penalty in excess of the amounts set forth above for Class I or Class II violations, then the lowest amounts required by such federal law or regulations shall become the maximum civil penalties under this section. The date of notification under this section shall be deemed to be the date of receipt by the facility of written notice of the alleged Class I or Class II violation, which notice shall include specifics of the violation charged and which notice shall be hand delivered or sent by overnight express mail or by registered or certified mail, return receipt requested.

All civil penalties received pursuant to this subsection shall be paid into a special fund of the Department for the cost of implementation of this section, to be applied to the protection of the health or property of residents or patients of facilities that the Commissioner or the United States Secretary of Health and Human Services finds in violation, including payment for the costs for relocation of patients, maintenance of temporary management or receivership to operate a facility pending correction of a violation, and for reimbursement to residents or patients of lost personal funds.

B. In addition to the remedies provided in §§ 32.1-27 and 32.1-27.2 and the civil penalties set forth in subsection A, the Commissioner may petition the circuit court for the jurisdiction in which any nursing home or certified nursing facility as defined in § 32.1-123 is located for the appointment of a receiver in accordance with the provisions of this subsection whenever such nursing home or certified nursing facility shall (i) receive official notice from the Commissioner that its license has been or will be revoked or suspended, or that its Medicare or Medicaid certification has been or will be cancelled or revoked; or (ii) receive official notice from the United States Department of Health and Human Services or the Department of Medical Assistance Services that its provider agreement has been or will be revoked, cancelled, terminated or not renewed; or (iii) advise the Department of its intention to close or not to renew its license or Medicare or Medicaid provider agreement less than ninety days in advance; or (iv) operate at any time under conditions which present a major and continuing threat to the health, safety, security, rights or welfare of the patients, including the threat of imminent abandonment by the owner or operator, or a pattern of failure to meet ongoing financial obligations such as the inability to pay for essential food, pharmaceuticals, personnel, or required insurance; and (v) the Department is unable to make adequate and timely arrangements for relocating all patients who are receiving medical assistance under this chapter and Title XIX of the Social Security Act in order to ensure their continued safety and health care.

Upon the filing of a petition for appointment of a receiver, the court shall hold a hearing within ten days, at which time the Department and the owner or operator of the facility may participate and present evidence. The court may grant the petition if it finds any one of the conditions identified in (i) through (iv) to exist in combination with the condition identified in (v) and the court further finds that

such conditions will not be remedied and that the patients will not be protected unless the petition is granted.

No receivership established under this subsection shall continue in effect for more than 180 days without further order of the court, nor shall the receivership continue in effect following the revocation of the nursing home's license or the termination of the certified nursing facility's Medicare or Medicaid provider agreement, except to enforce any post-termination duties of the provider as required by the provisions of the Medicare or Medicaid provider agreement.

The appointed receiver shall be a person licensed as nursing home administrator in the Commonwealth pursuant to Title 54.1 or, if not so licensed, shall employ and supervise a person so licensed to administer the day-to-day business of the nursing home or certified nursing facility.

The receiver shall have (i) such powers and duties to manage the nursing home or certified nursing facility as the court may grant and direct, including but not limited to the duty to accomplish the orderly relocation of all patients and the right to refuse to admit new patients during the receivership, (ii) the power to receive, conserve, protect and disburse funds, including Medicare and Medicaid payments on behalf of the owner or operator of the nursing home or certified nursing facility, (iii) the power to execute and avoid executory contracts, (iv) the power to hire and discharge employees, and (v) the power to do all other acts, including the filing of such reports as the court may direct, subject to accounting to the court therefor and otherwise consistent with state and federal law, necessary to protect the patients from the threat or threats set forth in the original petitions, as well as such other threats arising thereafter or out of the same conditions.

The court may grant injunctive relief as it deems appropriate to the Department or to its receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

The court may terminate the receivership on the motion of the Department, the receiver, or the owner or operator, upon finding, after a hearing, that either (i) the conditions described in the petition have been substantially eliminated or remedied or (ii) all patients in the nursing home or certified nursing facility have been relocated. Within 30 days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he has taken possession and all funds collected.

All costs of administration of a receivership hereunder shall be paid by the receiver out of reimbursement to the nursing home or certified nursing facility from Medicare, Medicaid and other patient care collections. The court, after terminating such receivership, shall enter appropriate orders to ensure such payments upon its approval of the receiver's reports.

A receiver appointed under this section shall be an officer of the court, shall not be liable for conditions at the nursing home or certified nursing facility which existed or originated prior to his appointment and shall not be personally liable, except for his own gross negligence and intentional acts which result in

injuries to persons or damage to property at the nursing home or certified nursing facility during his receivership.

The provisions of this subsection shall not be construed to relieve any owner, operator or other party of any duty imposed by law or of any civil or criminal liability incurred by reason of any act or omission of such owner, operator, or other party.

1989, c. 618; 1996, cc. 788, 797; 2023, cc. 482, 483.

§ 32.1-27.2. (Effective July 1, 2025) Administrative sanctions.

A. Notwithstanding any other provision of law, the Commissioner may impose administrative sanctions in accordance with this section on any certified nursing facility, if that certified nursing facility does not comply with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127. The Commissioner shall not impose any administrative sanctions authorized under this section until regulations are promulgated pursuant to subsection G.

B. The Commissioner shall have authority to annually determine whether or not to impose any sanctions under subsection C for noncompliance with the provisions of regulations promulgated pursuant to subdivision B 32 of § 32.1-127, if the certified nursing facility:

1. Was affected by a declared emergency, or an act of God, that had an impact on the ability to hire or retain staff at levels required under subdivision B 32 of § 32.1-127. To the extent necessary, the Commissioner may review trended employment data for direct care staff, as provided by the certified nursing facility, to determine the effect of such emergencies or acts of God in assessing this criterion. Failure to provide adequate data may remove this criterion from the Commissioner's consideration;

2. Has made a concerted effort to recruit and retain direct care staff as evidenced through position advertisements, interviews, offers, financial incentives, and nonfinancial incentives. The certified nursing facility shall provide such evidence upon request of the Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the Commissioner's consideration; or

3. Was located in a medically underserved area and such location severely limited the ability of the certified nursing facility to recruit and retain direct care staff despite a concerted effort to recruit and retain direct care staff. The certified nursing facility shall provide evidence upon request of the Commissioner for consideration. Failure to provide adequate evidence may remove this criterion from the Commissioner's consideration.

C. Prior to restricting or prohibiting new admissions to a certified nursing facility, suspending or refusing to renew or reinstate any nursing home license, or revoking any nursing home license issued pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, the Commissioner shall first impose the following iterative administrative sanctions:

1. When a certified nursing facility is not in compliance with subdivision B 32 of § 32.1-127 and the conditions under subsection B do not exist, the Commissioner shall require the submission of an annual corrective action plan by a certified nursing facility and, upon approval of such plan by the

Commissioner, compliance with such plan. A corrective action plan shall only articulate strategies to be utilized to increase direct care staffing with the goal of compliance with subdivision B 32 of § 32.1-127 or improvement on the total nurse staffing hours metric, as defined by the Virginia Medicaid Nursing Facility Value-Based Purchasing (VBP) program. The Commissioner shall consider evidence of direct care staff hours provided in addition to the payroll based journal report, if requested by a certified nursing facility, and may or may not impose a corrective action plan under this section. The Commissioner shall consider the following:

a. If the annual measurement immediately subsequent to issuance of the corrective action plan shows compliance with subdivision B 32 of § 32.1-127, no additional administrative sanctions are warranted, and the corrective action plan is deemed inactive but shall be retained by the Commissioner pursuant to the Virginia Public Records Act (§ 42.1-76 et seq.); or

b. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B 32 of § 32.1-127, but the VBP program, as administered by the Department of Medical Assistance Services, indicates defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1; or

c. If the annual measurement immediately subsequent to issuance of the corrective action plan still shows noncompliance with subdivision B 32 of § 32.1-127, and the VBP program, as administered by the Department of Medical Assistance Services, does not indicate defined improvement on the total nurse staffing hours metric, the Commissioner shall repeat the provisions of subdivision 1 and may, under circumstances described, provide additional sanctions under subdivisions 2 and 3;

2. To the extent that any consecutive annual corrective action plan is required and results articulated in subdivision 1 c are obtained a second consecutive time, the Commissioner may impose a monetary penalty of up to $50,000 for each subsequent consecutive annual period in which compliance with subdivision B 32 of § 32.1-127 or defined improvement on the total nurse staffing hours metric under the VBP program is not attained; and

3. To the extent that a certified nursing facility is out of compliance with subdivision B 32 of § 32.1-127 or fails to show defined improvement on the total nurse staffing hours metric under the VBP program after three consecutive corrective action plans, the Commissioner may place the nursing home or certified nursing facility on probation.

D. A certified nursing facility sanctioned by the Commissioner shall retain responsibility for the health, safety, and welfare of any person under its care, including the timely transfer or relocation of such persons as may be deemed necessary by the Commissioner in compliance with state and federal discharge rights and protections for nursing home residents.

E. After deduction of the administrative costs of the Commissioner and the Department in furtherance of this section, any penalties collected under this section shall be paid to the special fund as set forth in § 32.1-27.1.

F. Prior to imposing administrative sanctions, the Commissioner shall provide the facility with reasonable notice. To the extent that sanctions are imposed, the facility shall be entitled to all rights under the Administrative Process Act (§ 2.2-4000 et seq.) and to a de novo appeal to circuit court.

G. The Board shall promulgate regulations to implement the provisions of this section consistent with the Administrative Process Act (§ 2.2-4000 et seq.).

2023, cc. 482, 483.

§ 32.1-28. When Attorney General to represent Board; special counsel.

The Attorney General shall represent the Board and Commissioner in all actions and proceedings for the enforcement of regulations or orders of the Board or Commissioner or the provisions of this title except actions or proceedings to which the Commonwealth or any of its agencies or institutions is a party defendant. Upon approval by the Governor, the Board is authorized to employ special counsel in such actions or proceedings.

1979, c. 711.

§ 32.1-29. Employment of attorney to defend Board members, employee, etc.

If the Commissioner, any Board member or any officer or employee of the Department is arrested, indicted or otherwise prosecuted on any criminal charge arising out of any act committed in the discharge of his duties as such, the Commissioner may employ an attorney approved by the Attorney General to defend such person. The compensation for such attorney shall, subject to the approval of the Attorney General, be paid out of the funds appropriated for the administration of the Department.

1979, c. 711.

Article 5 - Local Health Departments and Directors

§ 32.1-30. Local health departments.

Each county and city shall establish and maintain a local department of health that shall be headed by a local health director. Each such local health director shall (i) be a physician licensed to practice medicine in the Commonwealth, (ii) possess a master's or doctoral degree in the area of public health and have at least three years of professional experience in a full-time position in either a public health agency or public health-related position, or (iii) be otherwise qualified for the position as determined by the Commissioner. If a local health director is not a physician licensed to practice medicine and there is no licensed physician on staff, the local health director shall enter into a consulting agreement with a licensed physician to execute prescribing duties, consult on clinical matters, and perform all other duties as requested.

1979, c. 711; 2022, c. 804.

§ 32.1-31. Operation of local health department under contract with Board; local health services advisory boards; district health departments.

A. The governing body of any county or city may enter into a contract with the Board for the operation of the local health department in such county or city.

B. Each contract between a county or city and the Board shall specify the services to be provided in addition to the services required by law and shall contain such other provisions as the Board and the governing body of the county or city may agree upon.

C. Whenever in the opinion of the State Health Commissioner the operation of any local health departments operated under contractual agreement with the Board may be accomplished in a more efficient and economical manner by the consolidation of such local health departments, the Commissioner may propose the creation of a district health department composed of such local health departments. Such district health department shall be created by resolution duly adopted by the governing body of each county and city to be included in such district.

C1. The governing body of each city or county may appoint a local health services advisory board for the local health department that serves it. If a local health department serves more than one city or county, the governing bodies of the cities or counties that it serves shall be entitled to jointly appoint such a board. The board shall include representatives of health care providers, recipients of health department services, state and local agencies with programs operated in conjunction with the health department, and the public at large. No more than two elected officials shall serve on any board.

The number of members appointed to each local board shall not be less than ten nor more than fifteen.

The local board shall actively participate with community representatives in the formulation of a comprehensive plan for the development, coordination and evaluation of local health services systems and shall make formal recommendations to the governing authority or authorities at least annually concerning the comprehensive plan and its implementation during the ensuing year.

It shall be the responsibility of the local health director to:

1. Attend the meetings of the board;

2. Provide information concerning the operation of the local health department as requested by the board; and

3. Participate with the board in the preparation and review of the comprehensive plan.

D. Whenever a contract is entered into between a county or city and the Board as provided in this section, the Commissioner shall appoint the health director for the local health department. Whenever a district health department is formed as provided in this section, the Commissioner shall appoint a district health director who shall be deemed to be the local health director of each county and city in the district. Each health director appointed by the Commissioner shall be employed full time and shall be a state employee. Such health director shall perform such duties as may be prescribed in the contract or contracts and, with the approval of the Commissioner, any other health-related duties prescribed by local ordinances.

E. Every employee of a local or district health department operated under a contract with the Board shall be a state employee; but if such person was an employee of such political subdivision and a

member of the local retirement system on the effective date of any such contract and does not elect, in writing and within sixty days after the effective date of such contract, to become a member of the Commonwealth's retirement system, such employee shall remain a member of the local retirement system.

In any case in which the effective date of such contract of affiliation is prior to July 1, 1977, any member of the Virginia Retirement System who became a member by such election and who has withdrawn his contributions from the local retirement system may be credited with his creditable service in such local system upon payment to the Virginia Retirement System of an amount equal to five percent of his salary rate at the date of payment multiplied by the number of years of service to be credited. Such crediting of service shall be allowed only if such member files written request therefor with the Board prior to October 1, 1977.

Code 1950, §§ 32-40.1, 32-40.2; 1954, c. 508; 1966, c. 535; 1977, c. 620; 1979, c. 711; 1987, c. 206.

§ 32.1-32. Independent local health departments.

A. The governing body of any county or city which does not enter into a contract with the Board for the operation of the local health department shall appoint the local health director and may appoint a local board of health to establish policies and to advise the local health department.

B. Each local health director and local board of health appointed by a governing body as provided in this section shall enforce all health laws of this Commonwealth and regulations of the State Board of Health. In case any such local health director or local board fails to enforce any such laws or regulations, the Commissioner may apply to the appropriate circuit court for an injunction, writ of mandamus or other appropriate remedy to compel such local health director or local board to enforce such laws or regulations.

1979, c. 711.

§ 32.1-33. When Board to perform duties of local board.

If any governing body of a county or city which does not enter into a contract with the Board for the operation of the local health department does not appoint a local health director or establish a local health department, the Board may exercise the authority and perform the duties of the local health director or local health department until a local health director is appointed or local health department is established by the governing body. The compensation of all officers and agents appointed by the Board under this section and the expenses incurred by them shall be a charge upon and shall be paid by such governing body.

Code 1950, § 32-40; 1979, c. 711.

§ 32.1-34. Scope of local health ordinances and regulations.

No county, city or town ordinance or regulation shall be less stringent in the protection of the public health than any applicable state law or any applicable regulations of the Board.

1979, c. 711.

§ 32.1-34.1. Power to seek and receive donations.

Any health department operating under the provisions of this article is empowered to seek and accept grants, bequests or donations of money and resources from private persons in support of projects conducted under the auspices of the Virginia Health Care Foundation or other preventive or primary health care projects. A separate fund shall be established so as to segregate the amounts appropriated and the amounts bequeathed or contributed thereto. No portion of this fund derived from private contributions or bequests and designated for support of Virginia Health Care Foundation projects shall be used for any other purpose. Any money remaining in this fund at the end of the biennium shall not revert to the general fund but shall remain in the fund described herein. Interest earned on such moneys shall remain in this fund and be credited to it. Money bequeathed or contributed to this fund shall not be used to supplant local or state appropriations.

1995, c. 498.

§ 32.1-34.2. Human trafficking hotline; posted notice required.

Each local department of health shall post notice of the existence of a human trafficking hotline to alert possible witnesses or victims of human trafficking to the availability of a means to report crimes or gain assistance. The notice required by this section shall (i) be posted in a place readily visible and accessible to the public and (ii) meet the requirements specified in subsection C of § 40.1-11.3.

2018, c. 571.

§ 32.1-34.3. Funding local health departments; cooperative local health budget; report.

A. As used in this section:

"Cooperative local health budget" means the total amount of state funds, local matching funds, and estimated self-generated local service revenues allocated to support a local department of health.

"Estimated self-generated local service revenues" means the amount of funds projected to be received by a local department of health from fees charged to individuals or third-party payment sources for services and permits.

"Local matching funds" means the amount of funds that a county or city shall be required to contribute to the cooperative local health budget for the local health department that serves that county or city.

"Revenue generation capacity factor" means the result of a formula that (i) determines a county's or city's revenue capacity relative to the state revenue capacity, (ii) determines a county's or city's median household income relative to the statewide median household income, and (iii) adjusts the amount determined in clause (i) by the amount determined in clause (ii).

B. Funding for local health departments shall consist of such state funds as may be allocated for the operation of the local health department together with local matching funds and estimated self-generated local service revenues, the total amount of which shall constitute the collective local health budget available to a local department of health.

C. The amount of local matching funds a county or city shall be required to contribute to the cooperative local health budget shall be determined by the Department on the basis of the county's or city's

revenue generation capacity factor. However, in no case shall the amount of local matching funds required be greater than 45 percent or less than 18 percent of the total amount of the cooperative local health budget for the local health department that serves the county or city, after deducting estimated self-generated local service revenues.

D. The Department shall biennially review the local matching fund amount for each county and city in the Commonwealth and determine whether such amount should be revised as a result of changes to the county's or city's revenue generation capacity factor. The Department shall report the results of such review and any recommendations for changes to a county's or city's local matching fund amount to the Governor and the General Assembly.

2021, Sp. Sess. I, c. 203.

Chapter 2 - Disease Prevention and Control

Article 1 - REPORTING OF DISEASES

§ 32.1-35. List and reports of diseases and dangerous microbes and pathogens.

The Board shall promulgate from time to time a list of diseases, including diseases caused by exposure to any toxic substance as defined in § 32.1-239 and including diseases that may be caused by exposure to an agent or substance that has the potential for use as a weapon, that shall be required to be reported. The Board shall also promulgate from time to time a list of dangerous microbes and pathogens that shall be required to be reported by laboratories. The Board may classify such diseases, microbes and pathogens and prescribe the manner and time of such reporting.

Code 1950, § 32-16; 1979, c. 711; 2002, cc. 100, 768.

§ 32.1-35.1. Information on health care-associated infections.

Health care facilities that are required to report information about health care-associated infections to the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) pursuant to the Centers for Medicare and Medicaid Services reporting requirements shall release such data to the Board through the NHSN.

2005, c. 444; 2019, c. 293.

§ 32.1-36. Reports by physicians and laboratory directors.

A. Every physician practicing in this Commonwealth who shall diagnose or reasonably suspect that any patient of his has any disease required by the Board to be reported and every director of any laboratory doing business in this Commonwealth that performs any test whose results indicate the presence of any such disease shall make a report within such time and in such manner as may be prescribed by regulations of the Board. Any such report involving a disease that such physician or laboratory director has reason to believe may be caused by exposure to an agent or substance that has been or may be used as a weapon shall be reported directly to the Commissioner or his designee using an emergency response system maintained by the Department and operated twenty-four hours a day.

B. Any physician who diagnoses a venereal disease in a child twelve years of age or under shall, in addition to the requirements of subsection A hereof, report the matter, in accordance with the provisions of § 63.2-1509, unless the physician reasonably believes that the infection was acquired congenitally or by a means other than sexual abuse.

C. Any physician practicing in this Commonwealth shall report to the local health department the identity of any patient of his who has tested positive for exposure to human immunodeficiency virus as demonstrated by such test or tests as are approved by the Board for this purpose. However, there is no duty on the part of the physician to notify any third party other than the local health department of such test result, and a cause of action shall not arise from any failure to notify any other third party.

D. Upon investigation by the local health department of a patient reported pursuant to subsection A, the Commissioner may, to the extent permitted by law, disclose the patient's identity and disease to the patient's employer if the Commissioner determines that (i) the patient's employment responsibilities require contact with the public and (ii) the nature of the patient's disease and nature of contact with the public constitutes a threat to the public health.

The patient's identity and disease state shall be confidential as provided in §§ 32.1-36.1 and 32.1-41. Any unauthorized disclosure of reports made pursuant to this section shall be subject to the penalties of § 32.1-27.

E. Physicians and laboratory directors may voluntarily report additional information at the request of the Department of Health for special surveillance or other epidemiological studies.

F. 1. Every laboratory located in this Commonwealth shall file a written report with the Department of its inventory of dangerous microbes and pathogens on an annual basis. The laboratory shall supplement this report upon any change in such inventory as prescribed by the Board or immediately if any microbes or pathogens cannot be accounted for within twenty-four hours.

2. Except as provided in this subsection, a report submitted pursuant to this subsection shall be confidential and shall not be a public record pursuant to the Freedom of Information Act (§ 2.2-3700 et seq.). The Department shall cooperate with and may share information submitted to it pursuant to this subsection with the United States Centers for Disease Control and Prevention, and state and federal law-enforcement agencies in any investigation involving the release, theft or loss of a dangerous microbe or pathogen required to be reported under this subsection.

3. Any unauthorized disclosure of reports made pursuant to this subsection shall be subject to the penalties of § 32.1-27.

Code 1950, § 32-48; 1976, c. 628; 1979, c. 711; 1981, c. 282; 1988, c. 130; 1989, c. 613; 1995, c. 534; 1997, c. 271; 2002, cc. 100, 768.

§ 32.1-36.1. Confidentiality of test for human immunodeficiency virus; civil penalty; individual action for damages or penalty.

A. The results of every test to determine infection with human immunodeficiency virus shall be confidential. Such information may be released only to persons or entities permitted or authorized to obtain protected health information under any applicable federal or state law.

B. In any action brought under this section, if the court finds that a person has willfully or through gross negligence made an unauthorized disclosure in violation of this section, the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred may recover for the Literary Fund, upon petition to the court, a civil penalty of not more than $5,000 per violation.

C. Any person who is the subject of an unauthorized disclosure pursuant to this section shall be entitled to initiate an action to recover actual damages, if any, or $100, whichever is greater. In addition, such person may also be awarded reasonable attorney's fees and court costs.

D. This section shall not be deemed to create any duty on the part of any person who receives such test results, where none exists otherwise, to release the results to a person listed herein as authorized to receive them.

1989, c. 613; 1990, c. 777; 1993, cc. 97, 664; 2017, c. 178.

§ 32.1-37. Reports by persons other than physicians.

A. The person in charge of any medical care facility shall immediately make or cause to be made a report of a disease required by the Board to be reported when such information is available to that person and that person has reason to believe that no physician has reported such disease as provided in § 32.1-36. Such report shall be made to the local health director according to the provisions of the Board.

B. The person in charge of any residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school or summer camp as defined in § 35.1-1 shall immediately make or cause to be made a report of an outbreak of disease as defined by the Board. Such report shall be made by rapid means to the local health director or to the Commissioner.

C. The person in charge of any medical care facility, residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school, or summer camp as defined in § 35.1-1 may also voluntarily report additional information, including individual cases of communicable diseases, at the request of the Department of Health for special surveillance or other epidemiological studies.

Code 1950, § 32-49; 1979, c. 711; 1997, c. 271; 2008, cc. 367, 412.

§ 32.1-37.01. Posting of information about cases of communicable disease of public health threat.

A. As used in this section:

"Reporting entity" means a medical care facility, residential or day program, service or facility licensed or operated by any agency of the Commonwealth, school, or summer camp required to report an outbreak of a communicable disease pursuant to § 32.1-37.

B. Upon declaration of an emergency by the Governor pursuant to § 44-146.17 in response to a communicable disease of public health threat, the Department shall make information regarding outbreaks of such communicable disease of public health threat reported pursuant to § 32.1-37 available to the public on a website maintained by the Department, provided the release of such information does not violate the provisions of § 32.1-41. Such information shall include (i) the name of the reporting entity at which an outbreak of such communicable disease of public health threat has been reported; (ii) the number of confirmed cases of such communicable disease of public health threat reported by such reporting entity; and (iii) the number of deaths resulting from such communicable disease of public health threat reported by such reporting entity.

2020, Sp. Sess. I, cc. 12, 24.

§ 32.1-37.1. Report of diseases infecting dead human bodies.

Upon transferring custody of any dead body to any person practicing funeral services or his agent, any hospital, nursing facility or nursing home, assisted living facility, or correctional facility shall, at the time of transfer, notify the person practicing funeral services or his agent if the individual was known to have had immediately prior to death an infectious disease which may be transmitted through exposure to any bodily fluids.

Any facility or members of its staff specified in this section shall not be liable for injury resulting from ordinary negligence in failing to identify, as herein prescribed, a dead body of a person known to have had an infectious disease immediately prior to death.

The Board of Health shall determine the infectious diseases for which notification is required pursuant to this section.

1988, c. 836; 1993, cc. 957, 993.

§ 32.1-37.2. Consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.

A. Prior to performing any test to determine infection with human immunodeficiency virus, a medical care provider shall inform the patient that the test is planned, provide information about the test, and advise the patient that he has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.

B. Every person who has a confirmed positive test result for human immunodeficiency virus shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. Appropriate counseling shall include, but not be limited to, the meaning of the test results, the need for additional testing, the etiology, prevention and effects of acquired immunodeficiency syndrome, the availability of appropriate health care, mental health care and social services, the need to notify any person who may have been exposed to the virus and the availability of assistance through the Department of Health in notifying such individuals.

C. Opportunity for face-to-face disclosure of the test results and appropriate counseling shall not be required when the tests are conducted by blood collection agencies. However, all blood collection agencies shall notify the Board of Health of any positive tests.

D. In the case of a person applying for accident and sickness or life insurance who is the subject of a test to determine infection for human immunodeficiency virus, insurers' practices including an explanation of the meaning of the test, the manner of obtaining consent, the method of disclosure of the test results and any counseling requirements shall be as set forth in the regulations of the State Corporation Commission.

1989, c. 613; 2008, c. 641.

§ 32.1-38. Immunity from liability.

Any person making a report or disclosure required or authorized by this chapter, including any voluntary reports submitted at the request of the Department of Health for special surveillance or other epidemiological studies, shall be immune from civil liability or criminal penalty connected therewith unless such person acted with gross negligence or malicious intent. Further, except for such reporting requirements as may be established in this chapter or by any regulation promulgated pursuant thereto, there shall be no duty on the part of any blood collection agency or tissue bank to notify any other person of any reported test results, and a cause of action shall not arise from any failure by such entities to notify others. Neither the Commissioner nor any local health director shall disclose to the public the name of any person reported or the name of any person making a report pursuant to this chapter. No person making a report required or authorized by this chapter shall be responsible for recognizing agents or suspecting the presence of any conditions beyond the competence of a reasonable person practicing his profession; however, any such person shall be immune as provided in this section when making reports in good faith without gross negligence and within the usual scope of his practice.

Code 1950, § 32-48; 1976, c. 628; 1979, c. 711; 1988, c. 130; 1990, c. 777; 1997, c. 271; 2002, c. 768.

Article 2 - INVESTIGATION OF DISEASES

§ 32.1-39. Surveillance and investigation.

A. The Board shall provide for the surveillance of and investigation into all preventable diseases and epidemics in this Commonwealth and into the means for the prevention of such diseases and epidemics. Surveillance and investigation may include contact tracing in accordance with the regulations of the Board. When any outbreak or unusual occurrence of a preventable disease shall be identified through reports required pursuant to Article 1 (§ 32.1-35 et seq.) of this chapter, the Commissioner or his designee shall investigate the disease in cooperation with the local health director or directors in the area of the disease. If in the judgment of the Commissioner the resources of the locality are insufficient to provide for adequate investigation, he may assume direct responsibility and exclusive control of the investigation, applying such resources as he may have at his disposal. The Board may issue emergency regulations and orders to accomplish the investigation.

B. When an investigation of any outbreak or occurrence of a disease identified through reports required pursuant to Article 1 (§ 32.1-35 et seq.) of this chapter indicates the reasonable possibility that the outbreak or occurrence was the result of exposure to an agent or substance used as a weapon, the Commissioner or his designee shall immediately report such finding to the Department of State Police for investigation. Reports, records, materials or other data reported to the Department of State Police pursuant to this section shall remain confidential and shall not be subject to the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The Department of State Police, and any local law enforcement official, may release all or part of any report made or other information obtained pursuant to this section (i) where the release of such report or information may assist in the prevention of imminent harm to public health or safety, or (ii) where the release of such report or information, with patient identifying information removed, may be useful for education of the public on health, safety or homeland defense issues. Reports required by this section shall be maintained in the central repository established by the Department of State Police pursuant to the provisions of § 52-8.5. The Department of State Police shall immediately transmit the report to the local chief of police or sheriff with law-enforcement responsibilities both where the patient resides and where he sought the medical treatment that resulted in the report. In addition, the Department of State Police may transmit the report to federal and military law-enforcement authorities. The Department of State Police and local law-enforcement authorities shall immediately determine and implement the appropriate law-enforcement response to such reports, in accordance with their jurisdiction.

Code 1950, §§ 32-10, 32-42; 1979, c. 711; 1989, c. 613; 2002, c. 768.

§ 32.1-40. Authority of Commissioner to examine medical records.

Every practitioner of the healing arts and every person in charge of any medical care facility shall permit the Commissioner or his designee to examine and review any medical records which he has in his possession or to which he has access upon request of the Commissioner or his designee in the course of investigation, research or studies of diseases or deaths of public health importance. No such practitioner or person shall be liable in any action at law for permitting such examination and review.

Code 1950, § 32-10.1; 1960, c. 507; 1979, c. 711.

§ 32.1-41. Anonymity of patients and practitioners to be preserved in use of medical records.

The Commissioner or his designee shall preserve the anonymity of each patient and practitioner of the healing arts whose records are examined pursuant to § 32.1-40 except that the Commissioner, in his sole discretion, may divulge the identity of such patients and practitioners if pertinent to an investigation, research or study. Any person to whom such identities are divulged shall preserve their anonymity.

Code 1950, §§ 32-10.2, 32-10.3; 1960, c. 507; 1979, c. 711.

Article 3 - DISEASE CONTROL MEASURES

§ 32.1-42. Emergency rules and regulations.

The Board of Health may promulgate regulations and orders to meet any emergency or to prevent a potential emergency caused by a disease dangerous to public health, including, but not limited to, procedures specifically responding to any disease listed pursuant to § 32.1-35 that is determined to be caused by an agent or substance used as a weapon or any communicable disease of public health threat that is involved in an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

1979, c. 711; 2002, c. 768; 2004, cc. 773, 1021.

§ 32.1-42.1. Administration and dispensing of necessary drugs, devices and vaccines during a declared disaster or emergency.

A. The Commissioner, pursuant to § 54.1-3408, may authorize persons who are not authorized by law to administer or dispense drugs or devices to administer or dispense all necessary drugs or devices in accordance with protocols established by the Commissioner when (i) the Governor has declared a disaster or a state of emergency, the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency, or the Board has made an emergency order pursuant to § 32.1-13 for the purpose of suppressing nuisances dangerous to the public health and communicable, contagious, and infectious diseases and other dangers to the public life and health and for the limited purpose of administering vaccines as an approved countermeasure for such communicable, contagious, and infectious diseases; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control, and supervision of the Commissioner. For purposes of this section, "administer," "device," "dispense," and "drug" shall have the same meaning as provided in § 54.1-3401. The Commissioner shall develop protocols, in consultation with the Department of Health Professions, that address the required training of such persons and procedures for such persons to use in administering or dispensing drugs or devices.

B. Where the Commissioner, pursuant to subsection A, authorizes persons who are not otherwise authorized by law to administer vaccines, such persons shall include any of the following who, due to their education and training, are qualified to administer drugs: (i) any person licensed by a health regulatory board within the Department of Health Professions whose license is in good standing, or was in good standing within the 20 years immediately prior to lapsing; (ii) any emergency medical services provider licensed or certified by the Department whose license or certification is in good standing, or was in good standing within the 20 years immediately prior to lapsing; and (iii) any health professions student enrolled in an accredited program in the Commonwealth who is in good academic standing with such student's school and provided that the school certifies that the student has been properly trained in the administration of vaccines. A health professions student who administers vaccines pursuant to this section shall be supervised by any eligible health care provider who holds a license issued by a health regulatory board within the Department of Health Professions, and the supervising

health care provider shall not be required to be licensed in the same health profession for which the student is studying. A person who is licensed as an advanced practice registered nurse by the Boards of Medicine and Nursing or licensed as a physician assistant by the Board of Medicine who administers vaccines pursuant to this section may administer such vaccine without a written or electronic practice agreement. In the absence of gross negligence or willful misconduct, any such person authorized by the Commissioner or entity overseeing any such person who administers the vaccine pursuant to this section shall not be liable for (a) any actual or alleged injury or wrongful death or (b) any civil cause of action arising from any act or omission arising out of, related to, or alleged to have resulted in the contraction of or exposure to the communicable, contagious, and infectious disease or to have resulted from the administration of the vaccine.

2003, c. 794; 2007, cc. 699, 783; 2022, cc. 733, 774; 2023, c. 183.

§ 32.1-42.2. Declared emergency; priority for personal protective equipment and immunization; funeral service licensees and funeral service establishment employees.

In any case in which the Board or the Commissioner has made an emergency order or regulation to meet an emergency, not provided for by general regulations, for the purpose of suppressing nuisances dangerous to the public health or a communicable, contagious, or infectious disease or other danger to the public life and health, funeral service licensees and any person employed by a funeral service establishment shall be included in any group afforded priority with regard to (i) access to personal protective equipment and (ii) administration of any vaccination against such communicable disease of public health threat during such emergency.

2021, Sp. Sess. I, c. 216.

§ 32.1-43. Authority of State Health Commissioner to require quarantine, etc.

The State Health Commissioner shall have the authority to require quarantine, isolation, immunization, decontamination, or treatment of any individual or group of individuals when he determines any such measure to be necessary to control the spread of any disease of public health importance and the authority to issue orders of isolation pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of this chapter and orders of quarantine and orders of isolation under exceptional circumstances involving any communicable disease of public health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

Code 1950, § 32-8; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-44. Isolated or quarantined persons.

The provisions of this chapter shall be construed to allow any isolated or quarantined person to choose his own treatment, whenever practicable and in the best interest of the health and safety of the isolated or quarantined person and the public; however, the conditions of any order of isolation issued pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of this chapter involving a communicable disease of public health significance and any order of quarantine or order of isolation involving any communicable disease of public health threat pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter shall

remain in effect until the person or persons subject to such order of quarantine or order of isolation shall no longer constitute a threat to other persons.

Code 1950, § 32-13; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-45. Expense of treatment.

Except as specifically provided by law, the provisions of this chapter shall not be construed as relieving any individual of the expense, if any, of any treatment, including any person who is subject to an order of isolation issued pursuant to Article 3.01 (§ 32.1-48.01 et seq.) of this chapter or an order of quarantine or an order of isolation issued pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

Code 1950, § 32-56; 1973, c. 401; 1979, c. 711; 1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

C. For the purposes of this section, "health care provider" means any person, facility or agency licensed or certified to provide care or treatment by the Department of Health, Department of Behavioral Health and Developmental Services, Department of Rehabilitative Services, or the Department of Social Services, any person licensed or certified by a health regulatory board within the Department of Health Professions except for the Boards of Funeral Directors and Embalmers and Veterinary Medicine or any personal care agency contracting with the Department of Medical Assistance Services.

D. "Health care provider," as defined in subsection C, shall be deemed to include any person who renders emergency care or assistance, without compensation and in good faith, at the scene of an accident, fire, or any life-threatening emergency, or while en route therefrom to any hospital, medical clinic or doctor's office during the period while rendering such emergency care or assistance. The

Department of Health shall provide appropriate counseling and opportunity for face-to-face disclosure of any test results to any such person.

E. Whenever any law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider is directly exposed to body fluids of a person in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the person who was exposed. If the person whose body fluids were involved in the exposure is deceased, the decedent's next of kin shall be deemed to have consented to testing of the decedent's blood for infection with human immunodeficiency virus or hepatitis B or C viruses and release of such test results to the person who was exposed.

F. Whenever a person is directly exposed to the body fluids of a law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. The law-enforcement officer, salaried or volunteer firefighter, or salaried or volunteer emergency medical services provider shall also be deemed to have consented to the release of such test results to the person who was exposed.

G. For the purposes of this section, "law-enforcement officer" means a person who is both (i) engaged in his public duty at the time of such exposure and (ii) employed by any sheriff's office, any adult or youth correctional facility, or any state or local law-enforcement agency, or any agency or department under the direction and control of the Commonwealth or any local governing body that employs persons who have law-enforcement authority.

H. Whenever any school board employee is directly exposed to body fluids of any person in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the school board employee who was exposed.

I. Whenever any person is directly exposed to the body fluids of a school board employee in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the school board employee whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. The school board employee shall also be deemed to have consented to the release of such test results to the person.

J. For the purposes of this section, "school board employee" means a person who is both (i) acting in the course of employment at the time of such exposure and (ii) employed by any local school board in the Commonwealth.

K. For purposes of this section, if the person whose blood specimen is sought for testing is a minor, consent for obtaining such specimen shall be obtained from the parent, guardian, or person standing in loco parentis of such minor prior to initiating such testing. If the parent or guardian or person standing in loco parentis withholds such consent, or is not reasonably available, the person potentially exposed to the human immunodeficiency virus or hepatitis B or C viruses, or the employer of such person, may petition the juvenile and domestic relations district court in the county or city where the minor resides or resided, or, in the case of a nonresident, the county or city where the health care provider, law-enforcement agency or school board has its principal office or, in the case of a health care provider rendering emergency care pursuant to subsection D, the county or city where the exposure occurred, for an order requiring the minor to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section.

L. Except as provided in subsection K, if the person whose blood specimen is sought for testing refuses to provide such specimen, any person identified by this section who was potentially exposed to the human immunodeficiency virus or the hepatitis B or C viruses in the manner described by this section, or the employer of such person, may petition, on a form to be provided by the Office of the Executive Secretary of the Supreme Court of Virginia, the general district court of the county or city in which the person whose specimen is sought resides or resided, or, in the case of a nonresident, the county or city where the health care provider, law-enforcement agency or school board has its principal office or, in the case of a health care provider rendering emergency care pursuant to subsection D, the county or city where the exposure occurred, for an order requiring the person to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section. A hearing on such a petition shall be given precedence on the docket so as to be heard by the court within 48 hours of the filing of the petition, or, if the court is closed during such time period, such petition shall be heard on the next day that the court is in session. A copy of the petition, which shall specify the date and location of the hearing, shall be provided to the person whose specimen is sought. At any hearing before the court, the person whose specimen is sought or his counsel may appear. The court may be advised by the Commissioner or his designee prior to entering any testing order. If the general district court determines that there is probable cause to believe that a person identified by this section has been exposed in the manner prescribed by this section, the court shall issue an order requiring the person whose bodily fluids were involved in the exposure to provide a blood specimen or to submit to testing and to disclose the test results in accordance with this section. If a testing order is issued, both the petitioner and the person from whom the blood specimen is sought shall receive counseling and opportunity for face-to-face disclosure of any test results by a licensed practitioner or trained counselor.

M. Any person who is subject to a testing order may appeal the order of the general district court to the circuit court of the same jurisdiction within 10 days of receiving notice of the order. Any hearing conducted pursuant to this subsection shall be held in camera as soon as practicable. The record shall be sealed. The order of the circuit court shall be final and nonappealable.

N. No specimen obtained pursuant to this section shall be tested for any purpose other than for the purpose provided for in this section, nor shall the specimen or the results of any testing pursuant to this section be used for any purpose in any criminal matter or investigation. Any violation of this subsection shall constitute reversible error in any criminal case in which the specimen or results were used.

1989, c. 613; 1993, c. 315; 1994, cc. 230, 236; 1997, c. 869; 2003, c. 1; 2008, cc. 191, 339; 2009, cc. 96, 478, 552, 813, 840; 2015, cc. 51, 502, 503; 2019, c. 27; 2020, c. 502.

§ 32.1-45.2. Public safety employees; testing for blood-borne pathogens; procedure available for certain citizens; definitions.

A. If, in the course of employment, an employee of a public safety agency is involved in a possible exposure prone incident, the employee shall immediately, or as soon thereafter as practicable, notify the agency of the incident in accordance with the agency's procedures for reporting workplace accidents.

B. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred, and the person whose body fluids were involved in the exposure prone incident is deceased, the agency shall (i) immediately contact the custodian of the remains and request that a specimen of blood be preserved for testing and (ii) contact the next of kin of the decedent and inform the next of kin that the specimen will be tested for hepatitis B or C viruses and human immunodeficiency virus and the results of such testing released to the person who was exposed.

C. If, after reviewing the facts of the possible exposure prone incident with the employee and after medical consultation, the agency concludes that it is reasonable to believe that an exposure prone incident may have occurred and the person whose body fluids were involved in the exposure prone incident is alive, the agency shall request the person whose body fluids were involved to submit to testing for hepatitis B or C virus and human immunodeficiency virus as provided in § 32.1-37.2 and to authorize disclosure of the test results.

D. If a person is involved in a possible exposure prone incident involving the body fluids of an employee of a public safety agency, the person may request the agency to review the facts of the possible exposure prone incident for purposes of obtaining the employee's consent to test for hepatitis B or C virus and human immunodeficiency virus as provided in § 32.1-37.2 and to authorize disclosure of the test results. If, after reviewing the facts and after medical consultation, the agency concludes it is reasonable to believe an exposure prone incident involving the person and the employee may have

occurred, (i) the agency shall request the employee whose body fluids were involved to give consent to submit to testing for hepatitis B or C virus and human immunodeficiency virus and to authorize disclosure of the test results or (ii) if the employee is deceased, the agency shall request the custodian of the remains to preserve a specimen of blood and shall request the decedent's next of kin to provide consent, as provided in § 32.1-37.2, to such testing and to authorize disclosure of the test results.

E. If consent is refused under subsection C, the public safety agency or the employee may petition the general district court of the city or county in which the person resides or resided, or in the case of a nonresident, the city or county of the public safety agency's principal office, to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

If consent is refused under subsection D, the person involved in the possible exposure prone incident may petition the general district court of the city or county of the public safety agency's principal office to determine whether an exposure prone incident has occurred and to order testing and disclosure of the test results.

F. If the court finds by a preponderance of the evidence that an exposure prone incident has occurred, it shall order testing for hepatitis B or C virus and human immunodeficiency virus and disclosure of the test results. The court shall be advised by the Commissioner or his designee in making this finding. The hearing shall be held in camera as soon as practicable after the petition is filed. The record shall be sealed.

G. A party may appeal an order of the general district court to the circuit court of the same jurisdiction within ten days from the date of the order. Any such appeal shall be de novo, in camera, and shall be heard as soon as possible by the circuit court. The circuit court shall be advised by the Commissioner or his designee. The record shall be sealed. The order of the circuit court shall be final and nonappealable.

H. Disclosure of any test results provided by this section shall be made to the district health director of the jurisdiction in which the petition was brought or the district in which the person or employee was tested. The district health director or his designee shall inform the parties of the test results and counsel them in accordance with subsection B of § 32.1-37.2.

I. The results of the tests shall be confidential as provided in § 32.1-36.1.

J. No person known or suspected to be positive for infection with hepatitis B or C virus or human immunodeficiency virus shall be refused services for that reason by any public safety agency personnel.

K. For the purpose of this section and for no other purpose, the term "employee" shall include: (i) any person providing assistance to a person employed by a public safety agency who is directly affected by a possible exposure prone incident as a result of the specific crime or specific circumstances involved in the assistance and (ii) any victim of or witness to a crime who is directly affected by a possible exposure prone incident as a result of the specific crime.

L. This section shall not be deemed to create any duty on the part of any person where none exists otherwise, and a cause of action shall not arise from any failure to request consent or to consent to testing under this section. The remedies available under this section shall be exclusive.

M. For the purposes of this section:

"Exposure prone incident" means a direct exposure to body fluids of another person in a manner which may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit hepatitis B or C virus or human immunodeficiency virus and which occurred during the commission of a criminal act, during the performance of emergency procedures, care or assistance, or in the course of public safety or law-enforcement duties.

"Public safety agency" means any sheriff's office; any adult or youth correctional, law-enforcement, or fire safety organization; the Department of Forensic Science; or any agency or department that employs persons who have law-enforcement authority and which is under the direction and control of the Commonwealth or any local governing body.

1992, c. 711; 1994, c. 146; 1997, cc. 722, 804; 2008, c. 641; 2014, c. 275; 2020, c. 502.

§ 32.1-45.3. Repealed.

Repealed by Acts 2015, c. 301, cl. 1.

§ 32.1-45.4. Comprehensive harm reduction programs.

A. The Commissioner or his designee may authorize the director of a local department of health, or any other organization that promotes scientifically proven methods of mitigating health risks associated with drug use and other high-risk behaviors, to establish and operate local or regional comprehensive harm reduction programs that include the provision of sterile hypodermic needles and syringes and disposal of used hypodermic needles and syringes. The objectives of such programs shall be to (i) reduce the spread of HIV, viral hepatitis, and other blood-borne diseases in the Commonwealth; (ii) reduce the transmission of blood-borne diseases through needlestick injuries to law-enforcement and other emergency personnel; (iii) provide information to individuals who inject drugs regarding addiction recovery treatment services and encourage such individuals to participate in evidence-based substance use treatment programs; (iv) prevent opioid overdose deaths through distribution of naloxone or other opioid antagonists; and (v) incentivize the safe return and disposal of hypodermic needles and syringes. Comprehensive harm reduction programs established by the Commissioner pursuant to this section shall be operated by local health departments or affiliated organizations with which the Department contracts.

B. A comprehensive harm reduction program established pursuant to this section shall include (i) the disposal of used hypodermic needles and syringes; (ii) the provision of hypodermic needles and syringes and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused; (iii) reasonable and adequate security of program sites, equipment, and personnel; (iv) the provision of educational materials concerning (a) substance use disorder prevention, (b) overdose prevention, (c) the prevention of

transmission of HIV, viral hepatitis, and other blood-borne diseases, (d) available mental health treatment options, including referrals for mental health treatment, and (e) available substance use disorder treatment options, which shall include options for medication assisted treatment of substance use disorder, including referrals for treatment; (v) access to overdose prevention kits that contain naloxone or other opioid antagonist approved by the U.S. Food and Drug Administration for opioid overdose reversal; (vi) individual harm reduction counseling, including individual consultations regarding appropriate mental health or substance use disorder treatment; and (vii) verification that a hypodermic needle or syringe or other injection supplies were obtained from a comprehensive harm reduction program established pursuant to this section.

C. The director of a local health department or representative of any other organization authorized to establish a comprehensive harm reduction program pursuant to this section shall notify the Department, in a manner and form specified by the Department, of his intent to establish a comprehensive harm reduction program. Such notice shall include (i) the name of the local health department or organization that will operate the comprehensive harm reduction program, (ii) a description of the geographic area and population to be served by the comprehensive harm reduction program, and (iii) a description of the methods by which the comprehensive harm reduction program will comply with the requirements of subsection B, including a written security plan that provides for the reasonable and adequate security of the comprehensive harm reduction program site, equipment, and personnel.

D. Written security plans required pursuant to clause (iii) of subsection C shall be filed annually with each local law-enforcement agency serving the jurisdiction in which the comprehensive harm reduction program is located for their consideration.

E. The provisions of §§ 18.2-250, 18.2-265.3, and 54.1-3466 shall not apply to a person who dispenses or distributes hypodermic needles and syringes as part of a comprehensive harm reduction program established pursuant to this section.

F. The provisions of §§ 18.2-250, 18.2-265.3, and 54.1-3466 relating to possession of a controlled substance, drug paraphernalia, and controlled paraphernalia shall not apply to any person acting on behalf or for the benefit of a comprehensive harm reduction program when such possession is incidental to the provision of services as part of a comprehensive harm reduction program established pursuant to this section.

G. The provisions of §§ 18.2-250, 18.2-265.3, and 54.1-3466 relating to possession of a controlled substance, drug paraphernalia, and controlled paraphernalia shall not apply to any person receiving services from a comprehensive harm reduction program established pursuant to this section, when (i) such controlled substance is a residual amount contained in a used needle, used hypodermic syringe, or used injection supplies obtained from or returned to a comprehensive harm reduction program established pursuant to this section, or (ii) such paraphernalia is obtained from a comprehensive harm reduction program established pursuant to this section, as evidenced by the verification required pursuant to clause (vii) of subsection B.

H. Every local health department or other organization operating a comprehensive harm reduction program pursuant to this section shall report annually by July 1 to the Department regarding, for the previous calendar year, (i) the number of individuals served by the comprehensive harm reduction program; (ii) the number of needles, hypodermic syringes, and other injection supplies distributed by the comprehensive harm reduction program; (iii) the number of overdose prevention kits described in clause (v) of subsection B distributed by the comprehensive harm reduction program; and (iv) the number and type of referrals to mental health or substance use disorder treatment services provided to individuals served by the comprehensive harm reduction program, including the number of individuals referred to programs that provide naloxone or other opioid antagonists approved by the U.S. Food and Drug Administration for opioid overdose reversal.

I. Except in the case of a comprehensive harm reduction program established by the Commissioner, no state funds shall be used to purchase needles or hypodermic syringes distributed by a comprehensive harm reduction program established pursuant to this section.

2017, c. 183; 2020, c. 839.

§ 32.1-46. Immunization of patients against certain diseases.

A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The required immunizations for attendance at a public or private elementary, middle or secondary school, child care center, nursery school, family day care home, or developmental center shall be those set forth in the State Board of Health Regulations for the Immunization of School Children. The Board's regulations shall at a minimum require:

1. A minimum of three properly spaced doses of hepatitis B vaccine (HepB).

2. A minimum of three or more properly spaced doses of diphtheria toxoid. One dose shall be administered on or after the fourth birthday.

3. A minimum of three or more properly spaced doses of tetanus toxoid. One dose shall be administered on or after the fourth birthday.

4. A minimum of three or more properly spaced doses of acellular pertussis vaccine. One dose shall be administered on or after the fourth birthday. A booster dose shall be administered prior to entry into the seventh grade.

5. Two or three primary doses of Haemophilus influenzae type b (Hib) vaccine, depending on the manufacturer, for children up to 60 months of age.

6. Two properly spaced doses of live attenuated measles (rubeola) vaccine. The first dose shall be administered at age 12 months or older.

7. One dose of live attenuated rubella vaccine shall be administered at age 12 months or older.

8. One dose of live attenuated mumps vaccine shall be administered at age 12 months or older.

9. Two properly spaced doses of varicella vaccine. The first dose shall be administered at age 12 months or older.

10. Three or more properly spaced doses of oral polio vaccine (OPV) or inactivated polio vaccine (IPV). One dose shall be administered on or after the fourth birthday. A fourth dose shall be required if the three dose primary series consisted of a combination of OPV and IPV.

11. One to four doses, dependent on age at first dose, of properly spaced pneumococcal conjugate (PCV) vaccine for children up to 60 months of age.

12. Two doses of properly spaced human papillomavirus (HPV) vaccine. The first dose shall be administered before the child enters the seventh grade.

13. Two or three properly spaced doses of rotavirus vaccine, depending on the manufacturer, for children up to eight months of age.

14. Two properly spaced doses of hepatitis A vaccine (HAV). The first dose shall be administered at age 12 months or older.

15. Two properly spaced doses of meningococcal conjugate vaccine (MenACWY). The first dose shall be administered prior to entry to seventh grade. The second dose shall be administered prior to entry to twelfth grade.

The parent, guardian or person standing in loco parentis may have such child immunized by a physician, a physician assistant, an advanced practice registered nurse, a registered nurse, or a licensed practical nurse, or a pharmacist who administers pursuant to a valid prescription, or may present the child to the appropriate local health department, which shall administer the vaccines required by the State Board of Health Regulations for the Immunization of School Children without charge to the parent of or person standing in loco parentis to the child if (i) the child is eligible for the Vaccines for Children Program or (ii) the child is eligible for coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), or 10 U.S.C. § 1071 et seq. (CHAMPUS). In all cases in which a child is covered by a health carrier, Medicare, Medicaid, CHIP, or CHAMPUS, the Department shall seek reimbursement from the health carrier, Medicare, Medicaid, CHIP, or CHAMPUS for all allowable costs associated with the provision of the vaccine. For the purposes of this section, the Department shall be deemed a participating provider with a managed care health insurance plan as defined in § 32.1-137.1.

B. A physician, a physician assistant, an advanced practice registered nurse, a registered nurse, a licensed practical nurse, a pharmacist, or a local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate that shall state the diseases for which the child has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, the State Board of Health Regulations for the Immunization of School Children. The State Board of Health shall amend the State Board of Health Regulations for the Immunization of School Children as necessary from time to time to maintain conformity with evidence-based, routinely recommended vaccinations for children. The adoption of such regulations shall be exempt from the requirements of Article 2 (§ 2.2-4006 et seq.) of the Administrative Process Act (§ 2.2-4000 et seq.). However, the Department shall (i) provide a Notice of Intended Regulatory Action and (ii) provide for a 60-day public comment period prior to the Board's adoption of the regulations.

D. The provisions of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board;

2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia, a licensed advanced practice registered nurse, or a local health department that states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child; or

3. Because the human papillomavirus is not communicable in a school setting, a parent or guardian, at the parent's or guardian's sole discretion, may elect for the parent's or guardian's child not to receive the human papillomavirus vaccine, after having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the Board.

E. For the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations, any physician, physician assistant, advanced practice registered nurse, licensed institutional health care provider, or local or district health department, the Virginia Immunization Information System, and the Department of Health may share immunization and patient locator information without parental authorization, including, but not limited to, the month, day, and year of each administered immunization; the patient's name, address, telephone number, birth date, and social security number; and the parents' names. The immunization information; the patient's name, address, telephone number, birth date, and social security number; and the parents' names shall be confidential and shall only be shared for the purposes set out in this subsection.

F. The State Board of Health shall review this section annually and make recommendations for revision by September 1 to the Governor, the General Assembly, and the Joint Commission on Health Care.

Code 1950, § 32-57.1; 1968, c. 592; 1972, c. 558; 1979, c. 711; 1980, c. 410; 1989, c. 382; 1991, c. 133; 1992, cc. 127, 166; 1994, c. 62; 1995, cc. 729, 742; 1996, cc. 67, 533; 1999, cc. 632, 676, 738; 2000, c. 476; 2004, c. 855; 2005, cc. 643, 684; 2006, cc. 364, 396, 716; 2007, cc. 858, 922; 2011, c. 125; 2014, cc. 316, 344; 2016, c. 81; 2019, c. 222; 2020, c. 1223; 2023, c. 183.

§ 32.1-46.01. Virginia Immunization Information System.

A. The Board of Health shall establish the Virginia Immunization Information System (VIIS), a statewide immunization registry that consolidates patient immunization histories from birth to death into a complete, accurate, and definitive record that may be made available to participating health care providers throughout Virginia, to the extent funds are appropriated by the General Assembly or otherwise made available. The purposes of VIIS shall be to (i) protect the public health of all citizens of the Commonwealth, (ii) prevent under-immunization and over-immunization of children, (iii) ensure up-to-date recommendations for immunization scheduling to health care providers and the Board, (iv) generate parental reminder and recall notices and manufacturer recalls, (v) develop immunization coverage reports, (vi) identify areas of under-immunized population, and (vii) provide, in the event of a public health emergency, a mechanism for tracking the distribution and administration of immunizations, immune globulins, or other preventive medications or emergency treatments. Any health care provider, as defined in § 32.1-127.1:03, in the Commonwealth that administers immunizations shall report such patient immunization information to VIIS pursuant to this section.

B. The Board of Health shall promulgate regulations to implement the VIIS that shall address:

1. Registration of participants, including, but not limited to, a list of those health care entities that are authorized and required to participate and any forms and agreements necessary for compliance with the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services;

2. Procedures for confirming, continuing, and terminating participation and disciplining any participant for unauthorized use or disclosure of any VIIS data;

3. Procedures, timelines, and formats for reporting of immunizations by participants;

4. Procedures to provide for a secure system of data entry that may include encrypted online data entry or secure delivery of data files;

5. Procedures for incorporating the data reported on children's immunizations pursuant to subsection E of § 32.1-46;

6. The patient identifying data to be reported, including, but not limited to, the patient's name, date of birth, gender, telephone number, home address, birth place, and mother's maiden name;

7. The patient immunization information to be reported, including, but not necessarily limited to, the type of immunization administered (specified by current procedural terminology (CPT) code or Health Level 7 (HL7) code); date of administration; identity of administering person; lot number; and if present, any contraindications, or religious or medical exemptions;

8. Mechanisms for entering into data-sharing agreements with other state and regional immunization registries for the exchange, on a periodic nonemergency basis and in the event of a public health emergency, of patient immunization information, after receiving, in writing, satisfactory assurances for the preservation of confidentiality, a clear description of the data requested, specific details on the intended use of the data, and the identities of the persons with whom the data will be shared;

9. Procedures for the use of vital statistics data, including, but not necessarily limited to, the linking of birth certificates and death certificates;

10. Procedures for requesting immunization records that are in compliance with the requirements for disclosing health records set forth in § 32.1-127.1:03; such procedures shall address the approved uses for the requested data, to whom the data may be disclosed, and information on the provisions for disclosure of health records pursuant to § 32.1-127.1:03;

11. Procedures for releasing aggregate data, from which personal identifying data has been removed or redacted, to qualified persons for purposes of research, statistical analysis, and reporting; and

12. Procedures for the Commissioner of Health to access and release, as necessary, the data contained in VIIS in the event of an epidemic or an outbreak of any vaccine-preventable disease or the potential epidemic or epidemic of any disease of public health importance, public health significance, or public health threat for which a treatment or vaccine exists.

The Board's regulations shall also include any necessary definitions for the operation of VIIS; however, "health care entity," "health care plan," and "health care provider" shall be as defined in subsection B of § 32.1-127.1:03.

C. The establishment and implementation of VIIS is hereby declared to be a necessary public health activity to ensure the integrity of the health care system in Virginia and to prevent serious harm and serious threats to the health and safety of individuals and the public. Pursuant to the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services, covered entities may disclose protected health information to the secure system established for VIIS without obtaining consent or authorization for such disclosure. Such protected health information shall be used exclusively for the purposes established in this section.

D. The Board and Commissioner of Health, any employees of the health department, any participant, and any person authorized to report or disclose immunization data hereunder shall be immune from civil liability in connection therewith unless such person acted with gross negligence or malicious intent.

E. This section shall not diminish the responsibility of any physician or other person to maintain accurate patient immunization data or the responsibility of any parent, guardian, or person standing in loco parentis to cause a child to be immunized in accordance with the provisions of § 32.1-46. Further, this section shall not be construed to require the immunization of any person who objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, or any person for whom administration of immunizing agents would be detrimental to his health.

F. The Commissioner may authorize linkages between VIIS and other secure electronic databases that contain health records reported to the Department of Health, subject to all state and federal privacy laws and regulations. These health records may include newborn screening results reported pursuant to § 32.1-65, newborn hearing screening results reported pursuant to § 32.1-64.1, and blood-

lead level screening results reported pursuant to § 32.1-46.1. Health care providers authorized to use VIIS may view the health records of individuals to whom the providers are providing health care services.

2005, cc. 643, 684; 2012, c. 147; 2021, Sp. Sess. I, c. 211.

§ 32.1-46.02. Administration of influenza vaccine to minors.

The Board shall, together with the Board of Nursing and by August 31, 2009, develop and issue guidelines for the administration of influenza vaccine to minors by licensed pharmacists, registered nurses, licensed practical nurses, or emergency medical services providers who hold an emergency medical technician intermediate or emergency medical technician paramedic certification issued by the Commissioner pursuant to § 54.1-3408. Such guidelines shall require the consent of the minor's parent, guardian, or person standing in loco parentis and shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention.

2009, c. 110; 2010, cc. 179, 252; 2015, cc. 502, 503.

§ 32.1-46.1. Board to establish protocol for identification of children with elevated blood-lead levels.

The Board shall promulgate regulations establishing a protocol for the identification of children at risk for elevated blood-lead levels which shall (i) require blood-lead level testing at appropriate ages and frequencies, when indicated, (ii) provide for criteria for determining low risk for elevated blood-lead levels and when such blood-lead level testing is not indicated, and (iii) require physicians to make available to parents information on the dangers of lead poisoning, along with a list of available resources, as part of regular well check visits for all children.

As deemed necessary by the Board, the protocol may also address follow-up testing for children with elevated blood-lead levels, dissemination of the protocol or other information to relevant health care professionals, appropriate information for parents, and other means of preventing lead poisoning among children. In promulgating such regulations, the Board shall consider the guidelines of the Centers for Disease Control and Prevention and may consider such other materials relating to lead poisoning prevention, testing, and treatment as it deems appropriate. The Board may also establish procedures governing how health care providers and laboratories report results to the Department of Health.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing blood-lead level records and the Virginia Immunization Information System (VIIS) operated pursuant to § 32.1-46.01. The Commissioner may authorize health care providers authorized to view VIIS to view blood-lead level records of individuals to whom the providers are providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkages shall be subject to all applicable state and federal privacy laws and regulations.

2000, c. 907; 2003, c. 463; 2007, c. 691; 2012, c. 147.

§ 32.1-46.2. Certain testing or determination of low risk for elevated blood-lead levels required.

In accordance with the protocol required by § 32.1-46.1 and the regulations of the Board of Health promulgated thereto, the parent, guardian or other person standing in loco parentis of each child within the Commonwealth shall cause such child to be tested for elevated blood-lead levels or shall obtain a determination that the child is at low risk for elevated blood-lead levels.

The provisions of this section shall not apply to any child whose parent, guardian or other person having control or charge of such child shall object to such testing on the grounds that the procedure conflicts with his religious tenets or practices.

2000, c. 907.

§ 32.1-47. Exclusion from school of children not immunized.

Upon the identification of an outbreak, potential epidemic or epidemic of a vaccine-preventable disease in a public or private school, the Commissioner shall have the authority to require the exclusion from such school of all children who are not immunized against that disease.

1979, c. 711.

§ 32.1-47.1. Vaccination of children; plan enhancements.

The Department shall include in its vaccination plans procedures to ensure the prompt vaccination of all persons of school age in the Commonwealth, without preference regarding the manner of compliance with the compulsory school attendance law set forth in § 22.1-254, upon declaration of a public health emergency involving a vaccine-preventable disease and consent of the parent or guardian of the person of school age if such person is a minor or, if the person of school age is not a minor, of the person. Vaccination plans developed pursuant to this section shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention, and shall be subject to the same review and update requirements, process, and schedule as the State Emergency Operations Plan developed by the Department of Emergency Management pursuant to § 44-146.18.

2010, c. 73.

§ 32.1-48. Powers of Commissioner in epidemic.

A. Nothing in this article shall preclude the Commissioner from requiring immediate immunization of all persons in case of an epidemic of any disease of public health importance for which a vaccine exists other than a person to whose health the administration of a vaccine would be detrimental as certified in writing by a physician licensed to practice medicine in this Commonwealth.

B. In addition, the State Health Commissioner shall hold the powers conferred pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter to issue orders of quarantine or prepare orders of isolation for a communicable disease of public health threat.

1979, c. 711; 2004, cc. 773, 1021.

Article 3.01 - ISOLATION OF CERTAIN PERSONS WITH COMMUNICABLE DISEASES OF PUBLIC HEALTH SIGNIFICANCE

§ 32.1-48.01. Definitions.

As used in this article, unless the context requires a different meaning:

"Appropriate precautions" means those specific measures which have been demonstrated by current scientific evidence to assist in preventing transmission of a communicable disease of public health significance. Appropriate precautions will vary according to the disease.

"At-risk behavior" means engaging in acts which a person, who has been informed that he is infected with a communicable disease of public health significance, knows may infect other persons without taking appropriate precautions to protect the health of the other persons.

"Communicable disease of public health significance" means an illness of public health significance, as determined by the State Health Commissioner, caused by a specific or suspected infectious agent that may be transmitted directly or indirectly from one individual to another.

"Communicable disease of public health significance" shall include, but may not be limited to, infections caused by human immunodeficiency viruses, blood-borne pathogens, and tubercle bacillus. The State Health Commissioner may determine that diseases caused by other pathogens constitute communicable diseases of public health significance. Further, "a communicable disease of public health significance" shall become a "communicable disease of public health threat" upon the finding of the State Health Commissioner of exceptional circumstances pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of this chapter.

1990, c. 958; 2004, cc. 773, 1021.

§ 32.1-48.02. Investigations of verified reports or medical evidence; counseling; outpatient and emergency treatment orders; custody upon emergency order; application of article.

A. Upon receiving at least two verified reports or upon receiving medical evidence that any person who is reputed to know that he is infected with a communicable disease of public health significance is engaging in at-risk behavior, the Commissioner or his designee may conduct an investigation through an examination of the records of the Department and other medical records to determine the disease status of the individual and that there is cause to believe he is engaging in at-risk behavior.

B. If the investigation indicates that the person has a communicable disease of public health significance caused by a non-airborne microorganism and that there is cause to believe he is engaging in at-risk behavior, the Commissioner or his designee may issue an order for such person to report to the local or district health department in the jurisdiction in which he resides to receive counseling on the etiology, effects and prevention of the specific disease of public health significance. The person conducting the counseling shall prepare and submit a report to the Commissioner or his designee on the counseling session or sessions in which he shall document that the person so counseled has been informed about the acts that constitute at-risk behavior, appropriate precautions, and the need to

use appropriate precautions. The counselor shall also report any statements indicating the intentions or understanding of the person so counseled.

C. If the investigation, described in subsection A, indicates that the person has a communicable disease of public health significance caused by an airborne microorganism, such as tubercle bacillus, that causes serious disease and can result in death and that the person has refused or failed to adhere to a prescribed course of treatment and, despite counseling, is engaging in conduct that places uninfected persons at risk of contracting such airborne communicable disease of public health significance, the Commissioner or his designee may issue an outpatient treatment order for such person to report to the local or district health department in the jurisdiction in which he resides to receive appropriate outpatient treatment and education concerning his disease.

D. If the investigation, described in subsection A, indicates that the person has a communicable disease of public health significance caused by an airborne microorganism, such as tubercle bacillus, which causes serious disease and can result in death and, despite documented and appropriate counseling, is engaging in conduct that unreasonably places uninfected persons at risk of contracting such airborne communicable disease of public health significance, such as tuberculosis, and medical data demonstrate that he poses an imminent threat to the health of others, the Commissioner may issue an emergency order requiring such person to be taken immediately into custody and placed, for a period, not to exceed 48 hours, in the least restrictive, willing facility providing protection of the health of others and appropriate treatment to the person upon finding that at least one of the following conditions is met:

1. The person has refused or failed to report to the local health department after having been ordered to do so pursuant to subsection C, for appropriate outpatient treatment and education concerning his disease;

2. The person has a documented history of failure to adhere to a prescribed course of treatment; or

3. Documentation exists that the person has indicated that he will not comply with the prescribed treatment.

If the specified 48-hour period terminates on a Saturday, Sunday or legal holiday, such person may be detained until the next day which is not a Saturday, Sunday, or legal holiday. During this period, the Commissioner shall proceed in accordance with § 32.1-48.03.

E. In order to implement an emergency order issued pursuant to subsection D of this section, all state and local law-enforcement officers are authorized to take custody of the subject of such emergency order immediately upon issuance of the emergency order by the Commissioner.

F. The provisions of this article shall only apply to communicable diseases of public health significance and shall not apply to communicable diseases of public health threat.

1990, c. 958; 1993, c. 705; 2001, c. 837; 2004, cc. 773, 1021.

§ 32.1-48.03. Petition for hearing; temporary detention.

A. Upon receiving a verified report or upon receiving medical evidence that any person who has been counseled pursuant to § 32.1-48.02 has continued to engage in at-risk behavior, the Commissioner or his designee may petition the general district court of the county or city in which such person resides to order the person to appear before the court to determine whether isolation is necessary to protect the public health from the risk of infection with a communicable disease of public health significance.

B. If such person cannot be conveniently brought before the court, the court may issue an order of temporary detention. The officer executing the order of temporary detention shall order such person to remain confined in his home or another's residence or in some convenient and willing institution or other willing place for a period not to exceed 48 hours prior to a hearing. An electronic device may be used to enforce such detention in the person's home or another's residence. The institution or other place of temporary detention shall not include a jail or other place of confinement for persons charged with criminal offenses.

If the specified 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, such person may be detained until the next day which is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

C. Any person ordered to appear before the court pursuant to this section shall be informed of his right to be represented by counsel. The court shall provide the person with reasonable opportunity to employ counsel at his own expense, if so requested. If the person is not represented by counsel, the court shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of $75 and his necessary expenses.

1990, c. 958; 2001, c. 837; 2004, cc. 773, 1021.

§ 32.1-48.04. Isolation hearing; conditions; order for isolation; right to appeal.

A. The isolation hearing shall be held within 48 hours of the execution of any temporary detention order issued or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the isolation hearing shall be the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

Prior to the hearing, the court shall fully inform the person who is infected with the communicable disease of public health significance of the basis for his detention, if any, the basis upon which he may be isolated, and the right of appeal of its decision.

B. An order for isolation in the person's home or another's residence or an institution or other place, including a jail when no other reasonable alternative is available, may be issued upon a finding by the court that the following conditions are met:

1. The person is infected with a communicable disease of public health significance.

2. The person is engaging in at-risk behavior.

3. The person has demonstrated an intentional disregard for the health of the public by engaging in behavior which has placed others at risk for infection with the communicable disease of public health significance.

4. There is no other reasonable alternative means of reducing the risk to public health.

C. Any order for isolation in the person's home or another's residence or an institution or other place shall be valid for no more than 120 days, or for a shorter period of time if the Commissioner or his designee, or the court upon petition, determines that the person no longer poses a substantial threat to the health of others. Orders for isolation in the person's home or another's residence may be enforced through the use of electronic devices. Orders for isolation may include additional requirements such as participation in counseling or education programs. The court may, upon finding that the person no longer poses a substantial threat to the health of others, issue an order solely for participation in counseling or educational programs.

D. Isolation orders shall not be renewed without affording the person all rights conferred in this article.

Any person under an isolation order pursuant to this section shall have the right to appeal such order to the circuit court in the jurisdiction in which he resides. Such appeal shall be filed within 30 days from the date of the order. Notwithstanding the provisions of § 19.2-241 relating to the time within which the court shall set criminal cases for trial, any appeal of an isolation order shall be given priority over all other pending matters before the court, except those matters under appeal pursuant to § 37.2-821, and shall be heard as soon possible by the court. The clerk of the court from which an appeal is taken shall immediately transmit the record to the clerk of the appellate court.

The appeal shall be heard de novo. An order continuing the isolation shall only be entered if the conditions set forth in subsection B are met at the time the appeal is heard.

If the person under an isolation order is not represented by counsel, the judge shall appoint an attorney-at-law to represent him. Counsel so appointed shall be paid a fee of $150 and his necessary expenses. The order of the court from which the appeal is taken shall be defended by the attorney for the Commonwealth.

1990, c. 958; 2001, c. 837; 2004, cc. 773, 1021.

Article 3.02 - QUARANTINE AND ISOLATION OF PERSONS WITH COMMUNICABLE DISEASES OF PUBLIC HEALTH THREAT

§ 32.1-48.05. Application of article; determination of exceptional circumstances; regulations; duties of the State Health Commissioner not be delegated.

A. Upon a determination by the State Health Commissioner that exceptional circumstances exist relating to one or more persons in the Commonwealth who are known to have been exposed to or infected with or reasonably suspected to have been exposed to or infected with a communicable disease of public health threat and that such exceptional circumstances render the procedures of Article 3.01 (§ 32.1-48.01 et seq.) of this chapter to be insufficient control measures or that the individuals have failed

or refused to comply voluntarily with the control measures directed by the State Health Commissioner in response to a communicable disease of public health threat, the State Health Commissioner may invoke the provisions of this article relating to quarantine and isolation.

B. The Board of Health shall promulgate regulations for the implementation of this article that shall (i) address the circumstances that are subject to the application of Article 3.01 (§ 32.1-48.01 et seq.) of this chapter and the exceptional circumstances in which this article may be invoked by the State Health Commissioner; (ii) provide procedures to assure that any quarantine or isolation is implemented in the least restrictive environment; (iii) ensure that the essential needs of persons subject to an order of isolation issued pursuant to this article shall be met, including, but not limited to, food, water, and health care, e.g., medications, therapies, testing, and durable medical equipment; (iv) provide procedures for proper notice of orders of quarantine and orders of isolation; (v) provide procedures for the State Health Commissioner to issue an emergency detention order for persons for whom he has probable cause to believe that they may fail or refuse to comply with an order of quarantine or an order of isolation; and (vi) address any other issue or procedure covered herein that the Board deems to be properly the subject of regulation.

C. The powers granted to the State Health Commissioner pursuant to this article shall not be delegated to or invoked by any local or district health department director. However, in the event the State Health Commissioner, duly appointed and confirmed pursuant to § 32.1-17, shall be unable to perform his duties pursuant to this article, any Deputy Commissioner, appointed by the State Health Commissioner and approved by the Board pursuant to § 32.1-22, shall be authorized to invoke the provisions of this article.

2004, cc. 773, 1021.

§ 32.1-48.06. Definitions.

As used in this article, unless the context requires a different meaning:

"Affected area" means any part or the whole of the Commonwealth, which has been identified as where persons reside, or may be located, who are known to have been exposed to or infected with or who are reasonably suspected to have been exposed to or infected with a communicable disease of public health threat. "Affected area" shall include, but not be limited to, cities, counties, towns, and subsections of such areas, public and private property, buildings, and other structures.

"Communicable disease of public health threat" means an illness of public health significance, as determined by the State Health Commissioner in accordance with regulations of the Board of Health, caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual to another and has been found to create a risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or tuberculosis, unless used as a bioterrorism weapon. "Individual" shall include any companion animal. Further, whenever "person or persons" is used herein it shall be deemed, when the context requires it, to include any individual.

"Companion animal" means, consistent with the provisions of § 3.2-6500, any domestic or feral dog, domestic or feral cat, nonhuman primate, guinea pig, hamster, rabbit not raised for human food or fiber, exotic or native animal, reptile, exotic or native bird, or any feral animal or any animal under the care, custody, or ownership of a person or any animal that is bought, sold, traded, or bartered by any person. Agricultural animals, game species, or any animals regulated under federal law as research animals shall not be considered companion animals for the purposes of this article.

"Isolation" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are infected with or are reasonably suspected to be infected with a communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to other uninfected and unexposed individuals.

"Law-enforcement agency" means any sheriff's office, police department, adult or youth correctional officer, or other agency or department that employs persons who have law-enforcement authority that is under the direction and control of the Commonwealth or any local governing body. "Law-enforcement agency" shall include, by order of the Governor, the Virginia National Guard.

"Quarantine" means the physical separation, including confinement or restriction of movement, of an individual or individuals who are present within an affected area, as defined herein, or who are known to have been exposed or may reasonably be suspected to have been exposed to a communicable disease of public health threat and who do not yet show signs or symptoms of infection with the communicable disease of public health threat in order to prevent or limit the transmission of the communicable disease of public health threat to other unexposed and uninfected individuals.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.07. Conditions for invoking the provisions of this article.

A. Prior to issuing any order of quarantine or any order of isolation pursuant to this article, the State Health Commissioner shall ensure that:

1. Any quarantine or isolation is implemented in the least restrictive environment necessary to contain the communicable disease of public health threat;

2. Any quarantined persons shall be confined separately from any isolated persons, to the maximum extent practicable;

3. Upon determining that any quarantined person can be reasonably believed to have become infected with a communicable disease of public health threat, the infected person shall be promptly removed from quarantine and placed in isolation;

4. The health and disease status of any quarantined and isolated persons shall be monitored regularly to determine if such persons require continued quarantine or isolation;

5. Any quarantined or isolated persons shall be immediately released from quarantine or isolation upon a determination by the State Health Commissioner that such quarantined or isolated persons pose no risk of transmitting the communicable disease of public health threat to other persons; and

6. The site of any quarantine or isolation shall be, to the extent practicable, safely and hygienically maintained with adequate food, clothing, health care, and other essential needs made available to the persons who are subject to any order of quarantine or isolation.

B. All persons subject to an order of quarantine or an order of isolation shall comply with the order and the conditions governing their quarantine or isolation.

C. In the case of any person who has been quarantined or isolated in a location other than a medical care facility, the State Health Commissioner shall authorize health care professionals to enter the premises of quarantine or isolation. No person, other than such authorized health care professionals, shall enter the premises of quarantine or isolation, unless authorized by the State Health Commissioner. Upon determining that any person, who has entered the premises of quarantine or isolation, poses a threat to public health and safety, the State Health Commissioner may quarantine or isolate such person.

2004, cc. 773, 1021.

§ 32.1-48.08. Declaration of quarantine.

A. The State Health Commissioner may declare a quarantine of any person or persons or any affected area after he finds that the quarantine is the necessary means to contain a communicable disease of public health threat as defined in § 32.1-48.06 to which such person or persons or the people of an affected area have been or may have been exposed and thus may become infected.

B. The State Health Commissioner shall record his findings and any information on which he has relied in making the finding required for quarantine pursuant to subsection A. The State Health Commissioner's record of findings concerning any communicable disease of public health threat shall be confidential and shall not be disclosed in accordance with subdivision 12 of § 2.2-3705.5.

C. The State Health Commissioner may order the quarantined person or persons to remain in their residences, to remain in another place where they are present, or to report to a place or places designated by the State Health Commissioner for the duration of their quarantine. An electronic device may be used to enforce any such quarantine. The Commissioner's order of quarantine shall be for a duration consistent with the known incubation period for such disease or, if the incubation period is unknown, for a period anticipated as being consistent with the incubation period for other similar infectious agents.

2004, cc. 773, 1021; 2017, c. 778.

§ 32.1-48.09. Order of quarantine.

A. The State Health Commissioner shall, prior to placing any person or persons under quarantine, issue an order of quarantine that shall: (i) identify the communicable disease of public health threat that is reasonably believed to be involved and the reasons why exceptional circumstances apply and the quarantine is the necessary means to contain the risks of transmission of the disease; (ii) contain sufficient information to provide reasonable notice to persons who are affected by the order of quarantine that they are subject to the order; (iii) specify the means by which the quarantine is to be

implemented; (iv) establish clearly the geographic parameters of the quarantine, if involving an affected area; (v) specify the duration of the quarantine; (vi) provide sufficient directions for compliance with the quarantine to enable persons subject to the order to comply; (vii) provide timely opportunities, if not readily available under the circumstances, for the person or persons who are subject to the order to notify employers, next of kin or legally authorized representatives and the attorneys of their choice of the situation; (viii) specify the penalty or penalties that may be imposed for noncompliance with the order of quarantine pursuant to § 32.1-27; and (ix) include a copy of § 32.1-48.010 to inform any person or persons subject to an order of quarantine of the right to seek judicial review of the order.

B. No affected area shall be the subject to an order of quarantine issued by the State Health Commissioner unless the Governor, pursuant to the authority vested in him pursuant to Chapter 3.2 (§ 44-146.13 et seq.) of Title 44, has declared a state of emergency for such affected area of the Commonwealth.

C. The order of quarantine shall be delivered to any person or persons affected by the quarantine, in so far as practicable. However, if, in the opinion of the State Health Commissioner, the number of quarantined persons is too great to make delivery of copies of the order of quarantine to each person possible in a timely manner, or if the order of quarantine designates an affected area instead of a specific person or persons, the State Health Commissioner shall cause the order of quarantine to be communicated to the persons residing or located in the affected area.

D. The State Health Commissioner or his legal representative shall, as soon as practicable following the issuance of an order of quarantine, file a petition seeking an ex parte court review and confirmation of the quarantine.

E. The petition shall be filed in the circuit court for the city or county in which the person or persons resides or is located or, in the case of an affected area, in the circuit court of the affected jurisdiction or jurisdictions.

The petition shall include (i) a copy of the order of quarantine or all information contained in the State Health Commissioner's order of quarantine in some other format and (ii) a summary of the findings on which the Commissioner relied in deciding to issue the order of quarantine.

Upon receiving multiple orders of quarantine, the court may, on the motion of any party or on the court's own motion, consolidate the cases into a single proceeding for all orders when (i) there are common questions of law or fact relating to the individual claims or rights to be determined, (ii) the claims of the consolidated cases are substantially similar, and (iii) all parties to the orders will be adequately represented in the consolidation.

F. Prior to the expiration of the original order of quarantine, the Commissioner may extend the duration of the original order upon finding that such an extension is necessary. The Commissioner, or his legal representative, shall, as soon as practicable following the extension of an order of quarantine, file a petition seeking court review and confirmation of the order to extend the duration of the quarantine.

G. In reviewing the petition for review and confirmation of the order of quarantine or an extension of the order of quarantine, the court shall give due deference to the specialized expertise of the State Health Commissioner. The court shall grant the petition to confirm or extend the quarantine upon finding probable cause that quarantine was the necessary means to contain the disease of public health threat and is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

H. The State Health Commissioner may, if he reasonably believes that public disclosure of the information contained in the order of quarantine or the petition for court review and confirmation or extension of the order of quarantine will exacerbate the public health threat or compromise any current or future criminal investigation or compromise national security, file some or all of any petition relating to an order of quarantine under seal. After reviewing any information filed under seal by the State Health Commissioner, the court shall reseal the relevant materials to the extent necessary to protect public health and safety.

I. The State Health Commissioner shall ensure that the protected health information of any person or persons subject to the order of quarantine shall only be disclosed in compliance with § 32.1-127.1:03 of this title and the regulations relating to privacy of health records promulgated by the federal Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. § 1320d et seq.).

J. Any law-enforcement officer, state or local health department employee, or any other person designated by a law-enforcement officer or state or local health department employee is empowered and authorized to deliver an order of quarantine.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.010. Appeal of any order of quarantine.

A. Any person or persons subject to an order of quarantine or a court-ordered extension of any such order pursuant to this article may file an appeal of the order of quarantine as such order applies to such person or persons in the circuit court for the city or county in which the subject or subjects of the order reside or are located or the circuit court for the jurisdiction or jurisdictions for any affected area. Any petition for appeal shall be in writing, shall set forth the grounds on which the order of quarantine is being challenged vis-a-vis the subject person or persons or affected area, and shall be served upon the State Health Commissioner or his legal representative.

B. A hearing on the appeal of the order of quarantine shall be held within 48 hours of the filing of the petition for appeal or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the hearing shall be held on the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

In extraordinary circumstances, for good cause shown, the Commissioner may request a continuance of the hearing, which the court shall only grant after giving due regard to the rights of the affected

individuals, the protection of the public health and safety, the severity of the emergency, and the availability of witnesses and evidence.

C. Any person appealing an order of quarantine shall have the burden of proving that he is not properly the subject of the order of quarantine.

D. The filing of an appeal shall not stay any order of quarantine.

E. Upon receiving multiple appeals of an order of quarantine that applies to a group of persons or an affected area, the court may, on the motion of any party or on the court's own motion, consolidate the cases in a single proceeding for all appeals when (i) there are common questions of law or fact relating to the individual claims or rights to be determined; (ii) the claims of the consolidated cases are substantially similar; and (iii) all parties to the appeals will be adequately represented in the consolidation.

F. The circuit court shall not conduct a de novo review of the order of quarantine; however, the court shall consider the existing record and such supplemental evidence as the court shall consider relevant. The court shall conduct the hearing on an appeal of an order of quarantine in a manner that will protect the health and safety of court personnel, counsels, witnesses, and the general public and in accordance with rules of the Supreme Court of Virginia pursuant to subsection C of § 17.1-503. The court may, for good cause shown, hold all or any portion of the hearings in camera upon motion of any party or upon the court's own motion.

G. Upon completion of the hearing, the court may (i) vacate or modify the order of quarantine as such order applies to any person who filed the appeal and who is not, according to the record and the supplemental evidence, appropriately subject to the order of quarantine; (ii) vacate or modify the order of quarantine as such order applies to all persons who filed an appeal and who are not, according to the record and the supplemental evidence, appropriately subject to the order of quarantine; (iii) confirm the order of quarantine as it applies to any person or all appealing parties upon a finding that such person or persons are appropriately subject to the order of quarantine and that quarantine is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat; or (iv) confirm the order of quarantine as it applies to all persons subject to the order upon finding that all such persons are appropriately subject to the order of quarantine and that quarantine is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

In any case in which the court shall vacate the order of quarantine as it applies to any person who has filed a request for review of such order and who is subject to such order or as it applies to all persons seeking judicial review who are subject to such order, the person or persons shall be immediately released from quarantine unless such order to vacate the quarantine shall be stayed by the filing of an appeal to the Supreme Court or the Court of Appeals. Any party to the case may file an appeal of the

circuit court decisions to the Court of Appeals. Parties to the case shall include any person who is subject to an order of quarantine and has filed an appeal of such order with the circuit court and the State Health Commissioner.

H. Appeals of any final order of any circuit court regarding the State Health Commissioner's petition for review and confirmation or extension of an order of quarantine or any appeal of an order of quarantine by a person or persons who are subject to such order shall be appealable to the Court of Appeals, with an expedited review in accordance with the rules of the court pursuant to subsection C of § 17.1-503.

I. Appeals of any circuit court order relating to an order of quarantine shall not stay any order of quarantine.

J. Persons requesting judicial review of any order of quarantine shall have the right to be represented by an attorney in all proceedings. If the person is unable to afford an attorney, counsel shall be appointed for the person by the circuit court for the jurisdiction in which the person or persons who are subject to the order of quarantine reside or, in the case of an affected area, by the circuit court for the jurisdiction or jurisdictions for the affected area. Counsel so appointed shall be paid at a rate established by the Supreme Court of Virginia from the Commonwealth's criminal fund.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2021, Sp. Sess. I, c. 489.

§ 32.1-48.011. Isolation may be ordered under certain exceptional circumstances; Commissioner authorized to require hospitalization or other health care.

A. Whenever the State Health Commissioner makes a determination of exceptional circumstances pursuant to § 32.1-48.05 and that the isolation procedures set forth in Article 3.01 (§ 32.1-48.01 et seq.) of this chapter are insufficient control measures to contain a communicable disease of public health threat, the isolation procedures herein may be invoked.

B. The State Health Commissioner may order the isolation of a person or persons upon a finding that (i) such person or persons are infected with or may reasonably be suspected to be infected with a communicable disease of public health threat and (ii) isolation is necessary to protect the public health, to ensure such isolated person or persons receive appropriate medical treatment, and to protect health care providers and others who may come into contact with such infected person or persons.

C. The State Health Commissioner shall record his findings and any information on which he has relied in making the finding required for isolation pursuant to this section. The State Health Commissioner's record of findings concerning any communicable disease of public health threat that is involved in an order of isolation shall be confidential and shall not be disclosed in accordance with subdivision 12 of § 2.2-3705.5.

D. The Commissioner may order the isolated person or persons to remain in their places of residence, to remain in another place where they are present, or to report to a place or facility designated by the Commissioner for the duration of their isolation. An electronic device may be used to enforce any such

isolation. The Commissioner's order of isolation shall be for a duration consistent with the known course of such communicable disease of public health threat or, if the course of the disease is unknown or uncertain, for a period consistent with the probable course of the communicable disease of public health threat.

E. To the extent that persons subject to an order of isolation pursuant to this article require hospitalization or other health care services, the State Health Commissioner shall be authorized to require that such services be provided.

F. The State Health Commissioner shall also have the authority to monitor the medical condition of any person or persons subject to an order of isolation pursuant to this article through regular visits by public health nurses or such other means as the Commissioner shall determine to be necessary.

2004, cc. 773, 1021; 2017, c. 778.

§ 32.1-48.012. Isolation order.

A. The State Health Commissioner shall, prior to placing any person or persons in isolation, prepare a written order of isolation that shall: (i) identify the person or persons subject to such order of isolation; (ii) identify the site of isolation, which may, in the Commissioner's discretion, include the residence of any isolated individual; (iii) specify the date and time that isolation is to commence; (iv) identify the communicable disease of public health threat or the suspected communicable disease of public health threat with which the person or persons are known to be infected or reasonably suspected to be infected; (v) specify the bases for isolation, including why isolation is the necessary means to contain transmission of the disease, and any conditions of the isolation; (vi) provide timely opportunities, if not readily available under the circumstances, for the person or person who are subject to the order to notify employers, next of kin or legally authorized representatives and the attorneys of their choice of the situation; (vii) specify the penalty or penalties that may be imposed for noncompliance with order of isolation pursuant to § 32.1-27; and (viii) include a copy of § 32.1-48.013 to inform any person or persons subject to an order of isolation of the right to seek judicial review or the order.

B. No affected area shall be the subject of an order of isolation prepared by the State Health Commissioner unless the Governor, pursuant to the authority vested in him pursuant to Chapter 3.2 (§ 44-146.13 et seq.) of Title 44, has declared a state of emergency for such affected area of the Commonwealth.

C. The order of isolation shall be delivered to any person or persons affected by the isolation, in so far as practicable. However, if, in the opinion of the State Health Commissioner, the number of isolated persons is too great to make delivery of copies of the order of isolation to each person possible in a timely manner, or if the order of isolation designates an affected area instead of a specific person or persons, the State Health Commissioner shall cause the order of isolation to be communicated to the persons residing or located in the affected area.

D. The State Health Commissioner shall, as soon as practicable following the issuance of an order of isolation, file a petition seeking an ex parte court order to review and confirm the isolation.

E. The petition shall be filed in the circuit court for the city or county in which the person or persons resides or is located or, in the case of an affected area, in the circuit court of the affected jurisdiction or jurisdictions.

Upon receiving multiple orders of isolation, the court may, on the motion of any party or on the court's own motion, consolidate the cases into a single proceeding for all orders when (i) there are common questions of law or fact relating to the individual claims or rights to be determined, (ii) the claims of the cases are substantially similar, and (iii) all parties to the orders will be adequately represented in the consolidation.

F. The petition shall include (i) a copy of the order of isolation or all information contained in the State Health Commissioner's order of isolation in some other format and (ii) a summary of the findings on which the Commissioner relied in determining that an order of isolation was required to contain the transmission of the communicable disease of public health threat.

G. Prior to the expiration of the original order of isolation, the Commissioner may extend the duration of the original order upon finding that such an extension is necessary. The Commissioner, or his legal representative, shall, as soon as practicable following the extension of an order of isolation, file a petition seeking court review and confirmation of the order to extend the duration of the isolation.

H. In reviewing any petition for review and confirmation or extension of the order of isolation, the court shall give due deference to the specialized expertise of the State Health Commissioner. The court shall grant the petition to confirm or extend the isolation upon finding probable cause that isolation was the necessary means and remains the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

I. The State Health Commissioner may, if he reasonably believes that public disclosure of the information contained in the order of isolation or the petition for review and confirmation or extension of the order of isolation will exacerbate the public health threat or compromise any current or future criminal investigation or compromise national security, file some or all of any petition to extend an order of isolation under seal. After reviewing any information filed under seal by the State Health Commissioner, the court shall reseal the relevant materials to the extent necessary to protect public health and safety.

J. The State Health Commissioner shall ensure that the protected health information of any person or persons subject to the order of isolation shall only be disclosed in compliance with the regulations relating to privacy of health records promulgated by the federal Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996.

K. Any law-enforcement officer, state or local health department employee, or any other person designated by a law-enforcement officer or state or local health department employee is empowered and authorized to deliver an order of isolation.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.013. Appeal of any order of isolation.

A. Any person or persons subject to an order of isolation or a court-ordered confirmation or extension of any such order pursuant to this article may file an appeal of the order of isolation in the circuit court for the city or county in which such person or persons reside or are located or, in the case of an affected area, in the circuit court for any affected jurisdiction or jurisdictions. Any petition for appeal shall be in writing, shall set forth the grounds on which the order of isolation is being challenged vis-a-vis the subject person or persons or affected area, and shall be served upon the State Health Commissioner or his legal representative.

B. A hearing on the appeal of the order of isolation shall be held within 48 hours of the filing of the petition for appeal or, if the 48-hour period terminates on a Saturday, Sunday, legal holiday or day on which the court is lawfully closed, the hearing shall be held on the next day that is not a Saturday, Sunday, legal holiday or day on which the court is lawfully closed.

In extraordinary circumstances, for good cause shown, the Commissioner may request a continuance of the hearing, which the court shall only grant after giving due regard to the rights of the affected individuals, the protection of the public health and safety, the severity of the emergency, and the availability of witnesses and evidence.

C. Any person appealing an order of isolation shall have the burden of proving that he is not properly the subject of the order of isolation.

D. An appeal shall not stay any order of isolation.

E. Upon receiving multiple appeals of an order of isolation, the court may, on the motion of any party or on the court's own motion, consolidate the cases in a single proceeding for all appeals when (i) there are common questions of law or fact relating to the individual claims or rights to be determined; (ii) the claims of the consolidated cases are substantially similar; and (iii) all parties to the appeals will be adequately represented in the consolidation.

F. The circuit court shall not conduct a de novo review of the order of isolation; however, the court shall consider the existing record and such supplemental evidence as the court shall consider relevant. The court shall conduct the hearing on an appeal of an order of isolation in a manner that will protect the health and safety of court personnel, counsels, witnesses, and the general public and in accordance with rules of the Supreme Court of Virginia pursuant to subsection C of § 17.1-503. The court may, for good cause shown, hold all or any portion of the hearings in camera upon motion of any party or the court's own motion.

G. Upon completion of the hearing, the court may (i) vacate or modify the order of isolation as such order applies to any person who filed the appeal and who is not, according to the record and the supplemental evidence, appropriately subject to the order of isolation; (ii) vacate or modify the order of isolation as such order applies to all persons who filed an appeal and who are not, according to the record and the supplemental evidence, appropriately subject to the order of isolation; (iii) confirm the order of isolation as it applies to any person or all appealing parties upon a finding that such person or

persons are appropriately subject to the order of isolation and that isolation is being implemented in the least restrictive environment to address the public health threat effectively, given the reasonably available information on effective infection control measures and the nature of the communicable disease of public health threat; or (iv) confirm the order of isolation as it applies to all persons subject to the order upon finding that all such persons are appropriately subject to the order of isolation and that isolation is being implemented in the least restrictive environment to address the public health threat effectively given the reasonably available information on effective control measures and the nature of the communicable disease of public health threat.

In any case in which the court shall vacate the order of isolation as it applies to any person who has filed a request for review of such order and who is subject to such order or as it applies to all persons seeking judicial review who are subject to such order, the person or persons shall be immediately released from isolation unless such order to vacate the isolation shall be stayed by the filing of an appeal to the Court of Appeals. Any party to the case may file an appeal of the circuit court decisions to the Court of Appeals. Parties to the case shall include any person who is subject to an order of isolation and has filed an appeal of such order with the circuit court and the State Health Commissioner.

H. Appeals of any final order of any circuit court regarding the State Health Commissioner's petition for review and confirmation or extension of an order of isolation or any appeal of an order of isolation by a person or persons who are subject to such order shall be appealable to the Court of Appeals, with an expedited review in accordance with the rules of the court pursuant to subsection C of § 17.1-503.

I. Appeals of any circuit court order relating to an order of isolation shall not stay any order of isolation.

J. Persons appealing any order of isolation shall have the right to be represented by an attorney in all proceedings. If the person is unable to afford an attorney, counsel shall be appointed for the person by the circuit court for the jurisdiction in which the person or persons who are subject to the order of isolation reside or, in the case of an affected area, by the circuit court for the jurisdiction or jurisdictions for the affected area. Counsel so appointed shall be paid at a rate established by the Supreme Court of Virginia from the Commonwealth's criminal fund.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2021, Sp. Sess. I, c. 489.

§ 32.1-48.013:1. Electronic filings as protection from communicable disease.

Notwithstanding Rule 1:17 of the Supreme Court of Virginia, a court in its discretion may permit the electronic or facsimile filing of a petition, notice, brief, notice of appeal, or other legal document when such filing is necessary to expedite the proceedings or to protect the public, court officials, or others participating in the proceedings from exposure to a communicable disease.

2007, cc. 699, 783.

§ 32.1-48.014. Enforcement of orders of quarantine or isolation; penalties.

A. Any person who does not comply with a validly issued order of quarantine or order of isolation issued or prepared pursuant to this article shall be subject to the penalties provided in § 32.1-27, including, upon conviction, a Class 1 misdemeanor and payment of civil penalties.

B. Any order of quarantine or isolation shall be enforced by law-enforcement agencies, as directed by the State Health Commissioner. Any enforcement authority directed to law-enforcement agencies by the Commissioner shall expressly include, but need not be limited to, the power to detain or arrest any person or persons identified as in violation of any order of quarantine or isolation, or for whom probable cause exists that he may fail or refuse to comply with any such order.

Any person or persons so detained shall be held in the least restrictive environment that can provide any required health care or other services for such person.

C. Every attorney for the Commonwealth shall have the duty to prosecute, without delay, any violation of this chapter in accordance with the penalties set forth in § 32.1-27.

D. Pursuant to 42 U.S.C. § 264 et seq. and 42 C.F.R. Parts 70 and 71, any order of quarantine or isolation issued by the Director of the Centers for Disease Control and Prevention affecting the Commonwealth or the Metropolitan Washington Airports Authority may be enforced by local law-enforcement officers or officers of the Metropolitan Washington Airports Authority with jurisdiction over the facility involved in the quarantine or isolation order.

2004, cc. 773, 1021; 2007, cc. 699, 783.

§ 32.1-48.015. Authorization to disclose health records.

A. The provisions of this article are hereby declared to be necessary to prevent serious harm and serious threats to the health and safety of individuals and the public in Virginia for purposes of authorizing the State Health Commissioner or his designee to examine and review any health records of any person or persons subject to any order of quarantine or order of isolation pursuant to this article and the regulations of the Department of Health and Human Services promulgated in compliance with the Health Insurance Portability and Accountability Act of 1996, as amended. The State Health Commissioner shall authorize any designee in writing to so examine and review any health records of any person or persons subject to any order of quarantine or order of isolation pursuant to this article.

B. Pursuant to the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services, covered entities may disclose protected health information to the State Health Commissioner or his designee without obtaining consent or authorization for such disclosure from the person who is the subject of the records. Such protected health information shall be used to facilitate the health care of any person or persons who are subject to an order of quarantine or an order of isolation. The State Health Commissioner or his designee shall only redisclose such protected health information in compliance with the aforementioned federal regulations. Further, the protected health information disclosed to the State Health Commissioner or his designee shall be held confidential and shall not be disclosed pursuant to the provisions of subdivision 12 of § 2.2-3705.5.

C. Pursuant to subsection G of § 32.1-116.3, any person requesting or requiring any employee of a public safety agency as defined in subsection M of § 32.1-45.2 to arrest, transfer, or otherwise exercise custodial supervision over an individual known to the requesting person (i) to be infected with any communicable disease or (ii) to be subject to an order of quarantine or an order of isolation pursuant

to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 shall inform such employee of a public safety agency of the potential risk of exposure to a communicable disease.

2004, cc. 773, 1021; 2007, cc. 699, 783; 2017, c. 778; 2020, c. 502.

§ 32.1-48.016. Immunity from liability.

Any person, including a person who serves in a Medical Reserve Corps (MRC) unit or on a Community Emergency Response Team (CERT), who, in good faith and in the performance of his duties, acts in compliance with this article and the Board of Health's regulations shall not be liable for any civil damages for any act or omission resulting from such actions unless such act or omission was the result of gross negligence or willful misconduct.

2004, cc. 773, 1021; 2005, c. 474.

§ 32.1-48.017. Use of public or private property or facilities.

A. Upon the declaration by the Governor of a state of emergency pursuant to § 44-146.17, the State Health Commissioner, acting in concert with the Governor, shall be authorized to require the use of any public or private property, building or facility to implement any order of quarantine or order of isolation. The State Health Commissioner and the Governor shall find, together, that the use of the property, building or facility is necessary and appropriate to enforce an order of quarantine or an order of isolation in the least restrictive environment.

B. If the Commissioner and the Governor elect to use any public or private property, building or facility pursuant to this article and this section, the Commissioner shall make accommodations, in conjunction with the owner or operator of the property, building or facility, for persons who are employed in, using or occupying the property, building or facility and who are not covered by the relevant order of quarantine or order of isolation.

C. Owners or operators of any property, building or facility so commandeered shall be entitled to compensation.

2004, cc. 773, 1021.

Article 3 - Disease Control Measures

§ 32.1-48.001. (For contingent effective date, see Acts 2021, Sp. Sess. I, c. 472, cl. 2) Real-time information sharing for emergency medical services agencies.

A. The Department shall develop and implement a system for sharing information regarding confirmed cases of communicable diseases of public health threat with emergency medical services agencies in real time during a declared public health emergency related to a communicable disease of public health threat, in order to protect the health and safety of emergency medical services personnel and the public. Such system shall include information about the location of confirmed cases of the communicable disease of public health threat, including the address of such location; the number of confirmed and suspected cases of the communicable disease of public health threat at each such location; any measures implemented at such location to prevent exposing others to the communicable

disease of public health threat; and any other information that the Department shall deem appropriate. Such system shall be updated in real time to reflect each confirmed case of the communicable disease of public health threat.

B. During a declared public health emergency related to a communicable disease of public health threat, every local and district health department in the Commonwealth shall report information regarding confirmed and suspected cases of the communicable disease of public health threat to the Department, in a format specified by the Board, for inclusion in the system developed pursuant to subsection A.

C. Information contained in the system developed pursuant to subsection A shall be made available to every emergency medical services agency in the Commonwealth and shall be used by such emergency medical services agencies for the purpose of (i) developing protocols to ensure the safety of emergency medical services personnel and the public when responding to calls for assistance at locations at which a case of the communicable disease of public health threat has been confirmed, including protocols related to appropriate staffing of the emergency medical services agency and the availability and use of appropriate equipment, including personal protective equipment, by emergency medical services personnel when responding to such calls, and (ii) during a declared public health emergency related to a communicable disease of public health threat, identifying specific locations at which a case of such communicable disease of public health threat has been confirmed for the purpose of implementing such protocols when responding to calls for assistance.

D. The Department shall make information submitted pursuant to subsection B and any other information contained in the system developed pursuant to subsection A available, upon request, to the Emergency Medical Services Advisory Board and each regional emergency medical services council, for the purpose of monitoring and improving the quality of emergency medical services in the Commonwealth.

E. The Department shall regularly consult with the Emergency Medical Services Advisory Board to identify the types of information that should be included in the system developed pursuant to subsection A and to revise reporting requirements for local and district health departments pursuant to subsection B.

F. Information contained in the system developed pursuant to subsection A shall be confidential and shall not be disclosed except in accordance with this section.

2021, Sp. Sess. I, c. 472.

Article 3.1 - Control of Rabies

§ 32.1-48.1. Regulation of State Health Commissioner declaring existence of rabies; display and publication.

Whenever the State Health Commissioner is informed that an outbreak of rabies has occurred in a county or city, he may, after consulting with the Commissioner of Agriculture and Consumer Services

and the Executive Director of the Department of Wildlife Resources, adopt a regulation declaring the existence of rabies in such county or city and containing such requirements as are hereinafter set forth. Such regulations shall be prominently displayed throughout the county or city and shall be published therein by signs or otherwise to call the attention of the public to the existence of such outbreak.

1954, c. 339, § 29-213.1; 1987, c. 488; 2020, c. 958.

§ 32.1-48.2. Regulation of Commissioner requiring vaccination or inoculation of dogs.

When the State Health Commissioner has declared that an outbreak of rabies exists in a county or city, he may adopt a regulation requiring all dogs therein to be vaccinated or inoculated against rabies, with such exceptions as he deems appropriate. Such regulation shall set forth the persons by whom and the time within which such vaccination or inoculation may be required. The State Health Commissioner may establish such clinics and furnish other services and supplies as will enable the prompt vaccination or inoculation of all dogs in such county or city.

1954, c. 339, § 29-213.2; 1987, c. 488.

§ 32.1-48.3. Regulations of Commissioner covering local ordinances and requirements.

If the governing body of the county or city in which the outbreak exists does not adopt, under § 3.2-6522, subsection A of § 3.2-6525, §§ 3.2-6538, 3.2-6539, and 3.2-6546, ordinances, regulations and measures to prohibit the running at large of dogs and to prevent the spread of rabies, the State Health Commissioner is authorized to adopt regulations providing for the matters contained in such sections and to enforce the same in the same manner as if they had been specifically adopted by the governing body of the county or city involved, and the provisions of such sections shall apply mutatis mutandis to the regulations adopted by the Commissioner hereunder.

1954, c. 339, § 29-213.3; 1987, c. 488; 2001, c. 674.

§ 32.1-48.4. Commissioner to cooperate with local governing bodies and agencies.

The Commissioner shall, insofar as practicable, cooperate with the local governing body and agencies of the county or city involved to the end that a joint program may be adopted and enforced for the reduction and elimination of rabies.

1954, c. 339, § 29-213.4; 1987, c. 488.

Article 4 - TUBERCULOSIS

§ 32.1-49. Tuberculosis required to be reported.

The Board shall include tuberculosis in the list of diseases provided for in § 32.1-35 which are required to be reported.

1979, c. 711.

§ 32.1-49.1. Definitions.

"Active tuberculosis disease" means a communicable disease caused by an airborne microorganism and characterized by the presence of either (i) a specimen of sputum or other bodily fluid or tissue that

has been found to contain tubercle bacilli as evidenced by culture or other definitive diagnostic test as established by the Commissioner, (ii) a specimen of sputum or other bodily fluid or tissue that is suspected to contain tubercle bacilli as evidenced by smear and sufficient clinical and radiographic evidence of active tuberculosis disease is present as determined by a physician licensed to practice medicine in the Commonwealth, or (iii) sufficient clinical and radiographic evidence of active tuberculosis disease as determined by the Commissioner is present, but a specimen of sputum or other bodily fluid or tissue containing or suspected to contain tubercle bacilli is unobtainable.

"Tubercle bacilli" means disease-causing organisms belonging to the Mycobacterium tuberculosis complex and includes Mycobacterium tuberculosis, Mycobacterium bovis, Mycobacterium africanum or other members as established by the Commissioner.

"Tuberculosis" means a disease caused by tubercle bacilli.

2001, c. 459.

§ 32.1-50. Examination of persons suspected of having active tuberculosis disease; reporting; report forms; report schedule; laboratory reports and required samples.

A. Any local health director may request any person having or reasonably suspected of having active tuberculosis disease to be examined immediately for the purpose of ascertaining the presence or absence of the disease. Such examination may be made by any licensed physician or licensed advanced practice registered nurse selected by such person at his own expense and approved by the local health director or by the local health director at no cost to such person.

B. Each physician or advanced practice registered nurse practicing in the Commonwealth who diagnoses or treats a person for active tuberculosis disease, or a physician assistant who treats a person for active tuberculosis disease, as defined in § 32.1-49.1 and each person in charge of a medical care facility providing inpatient or outpatient diagnosis or treatment for active tuberculosis disease shall report to the local health director within such time period and in such manner as may be prescribed by regulations of the Board. Such report, at a minimum, shall include an initial report when there are reasonable grounds to believe that a person has active tuberculosis disease, and a subsequent report when a person ceases treatment for tuberculosis disease. Cessation of treatment may be inferred when the person (i) fails to keep a scheduled appointment, (ii) relocates without transferring care, or (iii) discontinues care either upon or against the advice of the treating physician, physician assistant, or advanced practice registered nurse.

C. The initial disease report shall include the following: the affected person's name; date of birth; gender; address; pertinent clinical, radiographic, microbiologic, and pathologic reports, whether final or pending; such other information as is needed to locate the patient for follow-up; and any other information as prescribed by regulations of the Board.

D. Subsequent reports shall be submitted within such time, at such frequency, and in such manner as may be prescribed by regulations of the Board and shall provide updated clinical status, bacteriologic

and radiographic results, assessment of treatment adherence, name of current care provider, and any other information as prescribed by the Board.

E. Every director of any laboratory doing business in the Commonwealth shall, according to the manner and schedule as determined by the Board, report any result diagnostic of or highly correlated with active tuberculosis disease, whether testing is done in-house or referred to an out-of-state laboratory, including cultures positive for tubercle bacilli and smears suggestive of tubercle bacilli, and shall report the results of tests for antimicrobial susceptibility performed on cultures positive for tubercle bacilli. Each director of any laboratory shall also submit a representative and viable sample of the initial culture to the Virginia Division of Consolidated Laboratory Services or other laboratory designated by the Board to receive such specimen in order to (i) ensure testing for antimicrobial susceptibility on each initial isolate from a person with active tuberculosis disease, and (ii) establish a library of such isolates for the purpose of disease strain analysis as indicated by epidemiological investigations.

Code 1950, § 32-85.1; 1956, c. 482; 1979, c. 711; 2001, c. 459; 2004, c. 855; 2006, cc. 46, 396, 822; 2023, c. 183.

§ 32.1-50.1. Treatment plan; submission of plan and mediation of disagreements; determination of cure.

A. Each physician practicing in the Commonwealth who assumes responsibility for the treatment of a person for active tuberculosis as defined in this article and each person in charge of a medical care facility providing inpatient or outpatient treatment to a person with active tuberculosis shall, with the assistance and acknowledgement of that person, develop, maintain, and update as indicated, an individualized written plan of treatment tailored to the person's medical and personal needs and identifying the method for effective treatment and prevention of transmission. At a minimum, the plan shall specifically include verified patient address, name of the medical provider who has assumed responsibility for treatment, planned course of anti-tuberculosis drug therapy, estimated date of treatment completion, and means of ensuring successful completion of that treatment.

B. The written treatment plan shall upon request be submitted by the medical provider to the local health director in a manner determined by the Board and shall be subject to approval of the local health director. The Commissioner shall have the authority to settle, based on statewide standards, disagreements between the written plan so submitted and standards of care established by the local health director.

C. Each treating physician of or person in charge of a medical facility providing outpatient or inpatient care to a person with active tuberculosis disease shall maintain and submit to the local health director, upon his request, written documentation of that person's adherence to the treatment plan.

D. Each person in charge of a medical care facility providing inpatient treatment to a person with active tuberculosis disease and each person in charge of a state correctional or local correctional or detention facility that has in its custody a person with active tuberculosis shall submit to the local health director, in the manner determined by the Board, the plan of treatment for such person as

required in this article. The person in charge shall encourage the person to comply with such treatment plan; however, if such person with active tuberculosis indicates an unwillingness to comply with the treatment plan upon release, or exhibits behavior that indicates noncompliance, the person in charge, in conjunction with the local health director, may request the Commissioner to issue an emergency order requiring such person to be taken into custody pursuant to § 32.1-48.02 or other detention or custody options available pursuant to § 32.1-48.03 or § 32.1-48.04.

E. Once established in a person, active tuberculosis disease shall be considered present until (i) the person has received a complete and adequate course of antituberculosis drug therapy as established by the Commissioner in accordance with guidelines developed by the American Thoracic Society and Centers for Disease Control and Prevention and (ii) three successive cultures of specimens of sputum or other bodily fluid or tissue collected at intervals of no less than one week, or other definitive diagnostic test as established by the Commissioner demonstrate no viable tubercle bacilli, or the Commissioner or his designee determines that the clinical, laboratory, or radiographic evidence leads to a diagnosis other than active tuberculosis disease.

2001, c. 459.

§ 32.1-50.2. Administration of tuberculin purified protein derivative by nurses; policies and guidelines.

The Department shall issue policies and guidelines governing the possession and administration of tuberculin purified protein derivative (PPD) by registered nurses and licensed practical nurses pursuant to § 54.1-3408.

2003, c. 515.

§§ 32.1-51, 32.1-52. Repealed.

Repealed by Acts 1990, c. 958.

§ 32.1-53. Facilities and contracts for treatment of tuberculosis patients.

The Board may construct and operate hospitals and other facilities for the diagnosis and treatment of tuberculosis or enter into contractual arrangements with medical schools and hospitals in the Commonwealth for the care and treatment of tuberculosis patients.

Code 1950, § 32-312; 1979, c. 711.

§ 32.1-54. Commissioner authorized to charge patients for care.

When a tuberculosis patient is admitted to a facility operated by the Board or under contract with the Board, the Commissioner shall determine whether such patient or any person legally liable for such patient's support is able to pay in whole or in part for such patient's care. In making such determination, the Commissioner shall consider whether such patient or other person can make such payment and meet his other financial responsibilities for the support of himself and his family. Such determination may be made from time to time according to the circumstances of each case. If the Commissioner determines that a patient or person legally liable for his support can pay for the cost of his care or a portion thereof, the Commissioner shall collect for the cost of such care the actual average

per diem cost or such portion thereof as the Commissioner may determine the patient should pay. The Commissioner shall also collect any third-party payments as may be available for the care and treatment of such patient unless other contractual arrangements are made.

Code 1950, § 32-312.1; 1954, c. 698; 1956, c. 499; 1979, c. 711.

Article 5 - VENEREAL DISEASES

§ 32.1-55. Definition.

As used in this article, "venereal disease" includes syphilis, gonorrhea, chancroid, granuloma inguinale, lymphogranuloma venereum and any other sexually transmittable disease determined by the Board to be dangerous to the public health.

Code 1950, § 32-90; 1979, c. 711.

§ 32.1-55.1. Anonymous testing sites for human immunodeficiency virus.

From such funds as are appropriated for this purpose, the Board of Health shall make available in all health services areas of the Commonwealth anonymous testing for infection with human immunodeficiency virus.

1989, c. 613.

§ 32.1-56. Information to be provided patients.

It shall be the duty of every physician or other person who examines or treats a person having a venereal disease to provide such person with information about the disease, including, as a minimum, the nature of the disease, methods of treatment, measures used in preventing the spread of such disease, and the necessity of tests to ensure that a cure has been accomplished.

Code 1950, § 32-92; 1979, c. 711.

§ 32.1-57. Examination, testing and treatment; failure to comply with order of examination.

A. A local health director may require any person suspected of being infected with any venereal disease to submit to examination, testing and treatment if necessary.

B. If any such person refuses to submit to an examination, testing or treatment or to continue treatment until found to be cured by proper test, the local health director may apply to the appropriate circuit court for an order compelling such examination, testing or treatment. Any person willfully failing to comply with such order shall be punishable as for contempt of court.

C. If a person infected with venereal disease is required by the local health director to receive treatment therefor and such person receives such treatment from the local health department, no fee shall be charged.

Code 1950, § 32-93; 1979, c. 711; 1988, c. 399.

§ 32.1-58. Persons convicted of certain crimes to be examined, tested and treated.

Each person convicted of a violation of § 18.2-346, 18.2-346.01, or 18.2-361 shall be examined and tested for venereal disease and treated if necessary.

Code 1950, § 32-94; 1979, c. 711; 2021, Sp. Sess. I, c. 188.

§ 32.1-59. Examination and treatment in certain institutions.

Every person admitted to any state correctional institution and every person admitted to a state hospital or training center operated by the Department of Behavioral Health and Developmental Services shall be examined and tested for venereal disease. If the person is found to be infected with a venereal disease, the person in charge of such institution or state hospital or training center shall promptly provide treatment and shall report such case as provided in § 32.1-37.

Code 1950, § 32-104; 1979, c. 711; 2012, cc. 476, 507.

§ 32.1-60. Prenatal tests required.

Every physician, physician assistant, or advanced practice registered nurse attending a pregnant woman during gestation shall examine and test such woman for such venereal diseases as the Board may designate within 15 days after beginning such attendance. Every other person permitted by law to attend upon pregnant women but not permitted by law to make such examinations and tests shall cause such examinations and tests to be made by a licensed physician, licensed advanced practice registered nurse, or clinic. Serological tests required by this section may be performed by the Department of General Services, Division of Consolidated Laboratory Services (DCLS).

Code 1950, § 32-104.1; 1950, p. 108; 1979, c. 711; 1980, c. 184; 1984, c. 140; 1993, c. 364; 2004, c. 855; 2006, c. 396; 2023, c. 183.

Article 6 - PREVENTION OF BLINDNESS FROM OPHTHALMIA NEONATORUM

§ 32.1-61. Definition.

As used in this article, "ophthalmia neonatorum" means any inflammation, swelling or unusual redness in one or both eyes of any infant, either apart from or together with any unnatural discharge from the eye or eyes of such infant, independent of the nature of the infection, if any, occurring at any time within two weeks after the birth of such infant.

Code 1950, § 32-105; 1979, c. 711.

§ 32.1-62. Procedure upon infant's birth.

In order to prevent ophthalmia neonatorum, the physician, nurse or midwife in charge of the delivery of a baby or, if none, the first attending physician shall, immediately after the baby's birth, perform upon such baby the procedure prescribed by the Board. Such action shall be duly recorded in the medical record of the baby.

Code 1950, § 32-107; 1979, c. 711.

§ 32.1-63. Duty of physician, midwife or nurse noting ophthalmia neonatorum.

It shall be the duty of any physician, midwife or nurse who notes ophthalmia neonatorum within two weeks after the birth of an infant to perform or cause to be performed such tests as are necessary to ascertain the cause of such inflammation and to institute or have instituted appropriate therapy. When

the cause of such inflammation is ascertained to be gonococcus, such physician, nurse or midwife shall report the infection to the local health director or the Commissioner as provided in § 32.1-36.

Code 1950, § 32-106; 1979, c. 711.

§ 32.1-64. Duty of Board to provide for treatment.

The Board shall provide for the gratuitous distribution of the necessary treatment approved by it for ophthalmia neonatorum, together with proper directions for the use and administration thereof, to all physicians, midwives and hospitals requesting it. The Board shall provide free of charge in medically indigent cases the necessary treatment for ophthalmia neonatorum when the cause is ascertained to be gonococcus.

Code 1950, § 32-109; 1979, c. 711.

Article 6.1 - Virginia Hearing Loss Identification and Monitoring System

§ 32.1-64.1. Virginia Hearing Loss Identification and Monitoring System.

A. In order to identify hearing loss at the earliest possible age among newborns and to provide early intervention for all infants so identified as having hearing loss, the Commissioner shall establish and maintain the Virginia Hearing Loss Identification and Monitoring System. This system shall be for the purpose of identifying and monitoring infants with hearing loss to ensure that such infants receive appropriate early intervention through treatment, therapy, training, and education.

B. The Virginia Hearing Loss Identification and Monitoring System shall be initiated in all hospitals with neonatal intensive care services, in all hospitals in the Commonwealth having newborn nurseries, and in other birthing places or centers in the Commonwealth.

C. In all hospitals with neonatal intensive care services, the chief medical officer of such hospitals or his designee shall identify infants at risk of hearing loss using criteria established by the Board. Beginning on July 1, 1999, all infants shall be given a hearing screening test, regardless of whether or not the infant is at risk of hearing loss, by the chief medical officer or his designee using methodology approved by the Board. The test shall take place before the infant is discharged from the hospital to the care of the parent or guardian or as the Board may by regulation provide.

In all other hospitals and other birthing places or centers, the chief medical officer or his designee or the attending practitioner shall identify infants at risk of hearing loss using criteria established by the Board.

D. Beginning on July 1, 2000, the Board shall provide by regulation for the giving of hearing screening tests for all infants born in all hospitals. The Board's regulations shall establish when the testing shall be offered and performed and procedures for reporting.

An infant whose hearing screening indicates the need for a diagnostic audiological examination shall be offered such examination at a center approved by the Board of Health. As a condition of such approval, such centers shall maintain suitable audiological support and medical and educational referral practices.

E. The Commissioner shall appoint an advisory committee to assist in the design, implementation, and revision of this identification and monitoring system. The advisory committee shall meet at least four times per year. A chairman shall be elected annually by the advisory committee. The Department of Health shall provide support services to the advisory committee. The advisory committee shall consist of representatives from relevant groups including, but not limited to, the health insurance industry; physicians, including at least one pediatrician or family practitioner, one otolaryngologist, and one neonatologist; nurses representing newborn nurseries; audiologists; hearing aid dealers and fitters; teachers of the deaf and hard of hearing; parents of children who are deaf or hard of hearing; adults who are deaf or hard of hearing; hospital administrators; and personnel of appropriate state agencies, including the Department of Medical Assistance Services, the Department of Education, and the Department for the Deaf and Hard-of-Hearing. The Department of Education, the Department for the Deaf and Hard-of-Hearing, and the Department of Behavioral Health and Developmental Services shall cooperate with the Commissioner and the Board in implementing this system.

F. With the assistance of the advisory committee, the Board shall promulgate such rules and regulations as may be necessary to implement this identification and monitoring system. These rules and regulations shall include criteria, including current screening methodology, for the identification of infants (i) with hearing loss and (ii) at risk of hearing loss and shall include the scope of the information to be reported, reporting forms, screening protocols, appropriate mechanisms for follow-up, relationships between the identification and monitoring system and other state agency programs or activities, and mechanisms for review and evaluation of the activities of the system. The identification and monitoring system shall collect the name, address, sex, race, and any other information determined to be pertinent by the Board, for infants who are screened pursuant to this section.

G. In addition, the Board's regulations shall provide that any person making a determination that an infant (i) is at risk for hearing loss, (ii) has failed to pass a hearing screening, or (iii) was not successfully tested shall notify the parent or guardian of the infant, the infant's primary care practitioner, and the Commissioner. The Board may provide guidelines for the notification process.

H. No testing required to be performed or offered by this section shall be performed if the parents of the infant object to the test based on their bona fide religious convictions.

1986, c. 419; 1998, cc. 505, 506, 513; 2004, c. 855; 2009, cc. 813, 840; 2012, c. 147; 2019, c. 288.

§ 32.1-64.2. Confidentiality of records; publication; Commissioner required to contact parents, physicians, and relevant local early intervention program.

The Commissioner and all other persons to whom data is submitted pursuant to § 32.1-64.1 shall keep such information confidential. No publication of research or statistical data shall be made that identifies any infant with hearing loss or risk of hearing loss. The Commissioner shall contact the parents of children identified with hearing loss or at risk of hearing loss, their physicians, and the relevant local early intervention program to provide them with information about available public and private health care and educational resources, including any hearing loss clinics.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing newborn hearing screening records and the Virginia Immunization Information System (VIIS) operated pursuant to § 32.1-46.01. The Commissioner may authorize health care providers authorized to view VIIS to view newborn hearing screening records of individuals to whom the providers are providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkages shall be subject to all applicable state and federal privacy laws and regulations.

1986, c. 419; 1998, cc. 505, 506, 513; 2012, c. 147; 2019, c. 288.

Article 7 - Newborn Screening

§ 32.1-65. Certain newborn screening required.

In order to prevent intellectual disability and permanent disability or death, every infant who is born in the Commonwealth shall be subjected to screening tests for various disorders consistent with, but not necessarily identical to, the uniform condition panel recommended by the U.S. Secretary of Health and Human Services and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

Any infant whose parent or guardian objects thereto on the grounds that such tests conflict with his religious practices or tenets shall not be required to receive such screening tests.

The physician or certified nurse midwife in charge of the infant's care after delivery shall cause such tests to be performed. The screening tests shall be performed by the Division of Consolidated Laboratory Services or any other laboratory the Department of Health has contracted with to provide such service. Screening tests for time-critical disorders identified by the U.S. Department of Health and Human Services and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children shall be performed seven days a week.

The program for screening infants for sickle cell diseases shall be conducted in addition to the programs provided for in Article 8 (§ 32.1-68 et seq.).

Code 1950, §§ 32-112.1, 32-112.9; 1966, c. 179; 1979, c. 711; 1983, c. 582; 1986, c. 172; 1988, c. 97; 1992, cc. 747, 873; 2001, c. 255; 2002, c. 440; 2004, c. 760; 2005, cc. 717, 721; 2012, cc. 147, 476, 507; 2018, c. 531.

§ 32.1-65.1. Critical congenital heart defect screening test required.

In order to prevent disability or death, the Board shall require every hospital in the Commonwealth having a newborn nursery to perform a critical congenital heart defect screening test using pulse oximetry or other Board-approved screening test that is based on standards set forth by the American Academy of Pediatrics on every newborn in its care when such infant is at least 24 hours old but no more than 48 hours old or, in cases in which the infant is discharged from the hospital prior to reaching 24 hours of age, prior to discharging the infant.

Any infant whose parent or guardian objects thereto on the grounds that such tests conflict with his religious practices or tenets shall not be required to receive such screening tests.

The physician or health care provider in charge of the infant's care after delivery shall cause such tests to be performed.

2014, cc. 4, 175.

§ 32.1-66. Commissioner to notify physicians; reports to Commissioner.

Whenever a newborn screening test result indicates suspicion of any condition pursuant to § 32.1-65, the Commissioner shall notify forthwith the attending physician and shall perform or provide for additional testing required to confirm or disprove the diagnosis. All physicians, certified nurse midwives, public health nurses, or any nurse receiving such test result, and administrators of hospitals in the Commonwealth, shall report the discovery of all cases of any condition for which newborn screening is conducted pursuant to § 32.1-65 to the Commissioner for infants and children up to two years of age.

Code 1950, § 32-112.5; 1966, c. 179; 1979, c. 711; 1986, c. 172; 1988, c. 97; 2005, cc. 717, 721.

§ 32.1-67. Duty of Board for follow-up and referral protocols; regulations.

Infants identified with any condition for which newborn screening is conducted pursuant to § 32.1-65 or 32.1-65.1 shall be eligible for the services of the Children with Special Health Care Needs Program administered by the Department of Health. The Board of Health shall promulgate such regulations as may be necessary to implement Newborn Screening Services and the Children with Special Health Care Needs Program. The Board's regulations shall include, but not be limited to, a list of newborn screening tests conducted pursuant to §§ 32.1-65 and 32.1-65.1, notification processes conducted pursuant to § 32.1-66, follow-up procedures, appropriate referral processes, and services available for infants and children who have a heritable disorder or genetic disease identified through Newborn Screening Services.

Code 1950, § 32-112.6; 1966, c. 179; 1979, c. 711; 1980, c. 470; 1981, c. 164; 1986, c. 172; 1988, c. 97; 2000, c. 916; 2005, cc. 717, 721; 2012, c. 147; 2014, cc. 4, 175.

§ 32.1-67.1. Confidentiality of records; prohibition of discrimination.

The results of the newborn screening services conducted pursuant to this article may be used for research and collective statistical purposes. No publication of research or statistical data shall be made that identifies any infant having a heritable or genetic disorder.

The Commissioner may authorize linkages between secure electronic data systems maintained by the Department of Health containing newborn screening records and the Virginia Immunization Information System (VIIS) operated pursuant to § 32.1-46.01. The Commissioner may authorize health care providers authorized to view VIIS to view the newborn screening records of individuals to whom the providers are providing health care services. The records may be made available until the child reaches seven years of age, after which the records shall not be made available through a linkage to VIIS. Such linkages shall be subject to all applicable state and federal privacy laws and regulations.

1988, c. 97; 2005, cc. 717, 721; 2012, c. 147.

Article 8 - Voluntary Program for Control of Genetic and Metabolic Diseases

§ 32.1-68. Commissioner to establish screening and treatment program; review by Board; program to include education and post-screening counseling; laboratory tests.

A. The Commissioner, in cooperation with local health directors, shall establish a voluntary program for the screening of adults and children for the disease of sickle cell anemia or the sickle cell trait and for such other genetically related diseases and genetic traits and inborn errors of metabolism as the Board may deem necessary.

B. The Board shall review the program from time to time to determine the appropriate age and the method of screening for such conditions or traits in the light of technological changes.

C. The screening program shall include provisions for education concerning the nature and treatment of sickle cell anemia, other genetically related diseases and inborn errors of metabolism and a post-screening counseling program for the treatment of any person determined to have such a condition.

D. The program may include the provision of laboratory testing.

E. The Board shall adopt regulations to implement an adult and pediatric comprehensive sickle cell clinic network.

Code 1950, §§ 32-112.21, 32-112.22; 1973, c. 212; 1979, c. 711; 2020, c. 503.

§ 32.1-69. Records confidential; disclosure of results of screening.

The results of any particular screening program shall be sent to the physician of the person tested, if known, and either to the parents when the person screened is under the age of eighteen or to the person if he is eighteen years of age or over. The results of a screening program may be used for research and collective statistical purposes. Except as hereinabove provided, all records maintained as part of any screening program shall be strictly confidential and shall be accessible only to the Board, the Commissioner or his agents or to the local health director who is conducting the screening program except by explicit permission of the person who has been screened if such person is eighteen years of age or over or of such person's parent or guardian if he is under age eighteen.

Code 1950, § 32-112.23; 1973, c. 212; 1979, c. 711.

Article 8.1 - Virginia Congenital Anomalies Reporting and Education System

§ 32.1-69.1. Virginia Congenital Anomalies Reporting and Education System.

A. In order to collect data to evaluate the possible causes of stillbirths and birth defects, improve the diagnosis and treatment of birth defects, and establish a mechanism for informing the parents of children identified as having birth defects and their physicians about the health resources available to aid such children, the Commissioner shall establish and maintain a Virginia Congenital Anomalies Reporting and Education System using data from birth and death certificates and fetal death reports filed with the State Registrar of Vital Records and data obtained from hospital medical records. The

chief administrative officer of every hospital, as defined in § 32.1-123, shall make or cause to be made a report to the Commissioner of any stillbirth and any person under two years of age diagnosed as having a congenital anomaly. The Commissioner may appoint an advisory committee to assist in the design and implementation of this reporting and education system with representation from relevant groups, including, but not limited to, physicians, geneticists, personnel of appropriate state agencies, persons with disabilities, and the parents of children with disabilities.

B. The Commissioner shall provide for a secure system, which may include online data entry that protects the confidentiality of data and information for which reporting is required, to implement the Virginia Congenital Anomalies Reporting and Education System.

At a minimum, data collected shall include, but need not be limited to, the following: (i) the infant's first and last name, date of birth, gender, state of residence, birth hospital, physician's name, date of admission, date of discharge or transfer, and diagnosis; (ii) the first and last names of the infant's parents; (iii) the first and last name of the primary contact person for the infant; and (iv) data pertaining to stillbirths and birth defects reported by hospitals and derived from birth and death certificates and fetal death reports filed with the State Registrar of Vital Records and such other sources as may be authorized by the Commissioner.

The Commissioner, as he deems necessary to facilitate the follow-up of infants whose data and health record information have been entered into the system, may authorize the integration or linking of the Virginia Congenital Anomalies Reporting and Education System with other Department of Health population-based surveillance systems.

In addition, to minimize duplication and ensure accuracy during data entry, the Commissioner may authorize hospitals required to report stillbirth and birth defect data to the system to view such existing data and information as may be designated by the Commissioner.

With the assistance of the advisory committee, the Board shall promulgate such regulations as may be necessary to implement this reporting and education system.

C. As used in this section, "stillbirth" means an unintended, intrauterine fetal death occurring after a gestational period of 20 weeks.

1985, c. 273; 1986, c. 136; 1988, cc. 459, 843; 1994, c. 854; 2006, cc. 699, 906; 2015, c. 661; 2020, c. 900.

§ 32.1-69.1:1. Dissemination of information regarding birth defects.

The Commissioner shall develop a publication concerning the role of folic acid in the prevention of birth defects for distribution to physicians, hospitals and other medical facilities, and local health departments for use with patients. The publication shall be distributed by the Virginia Department of Health to the offices of the clerks of the circuit courts and made available to applicants for marriage licenses.

1999, c. 582; 2012, c. 802.

§ 32.1-69.2. Confidentiality of records; publication; authority of Commissioner to contact parents and physicians.

The Commissioner and all other persons to whom data is submitted pursuant to § 32.1-69.1 shall keep such information confidential. For the purpose of only complying with the provisions of § 32.1-69.1, hospitals required to report stillbirths, as defined in § 32.1-69.1, and birth defects to the Virginia Congenital Anomalies Reporting and Education System and provide patient follow-up may view personally identifiable information in the system as approved by the Commissioner and upon receipt by the Commissioner of sworn affirmation from each such person that the confidentiality of the information will be preserved. No publication of information shall be made except in the form of statistical or other studies which do not identify individuals. However, the Commissioner may contact the parents of children identified as having birth defects and their physicians to collect relevant data and to provide them with information about available public and private health care resources.

1985, c. 273; 2006, cc. 699, 906; 2015, c. 661.

Article 8.2 - Virginia Cord Blood Bank Initiative

§ 32.1-69.3. (Effective until date pursuant to Acts 2023, cc. 756 and 778, cl. 5) Virginia Cord Blood Bank Initiative established.

A. There is hereby established the Virginia Cord Blood Bank Initiative (hereinafter referred to as the Initiative) as a public resource for the treatment of patients with life-threatening diseases or debilitating conditions, for use in advancing basic and clinical research, and, in the event of a terrorist attack, to be used in the treatment of the injured.

The Initiative shall be established as a nonprofit legal entity to collect, screen for infectious and genetic diseases, perform tissue typing on, cryopreserve, and store umbilical cord blood as a public resource and shall be formed as a collaborative consortium that covers all geographical regions of Virginia.

B. The State Health Commissioner shall develop or shall arrange for or contract with a nonprofit entity for the development of the collaborative consortium to be known as the Initiative, which may consist of any entity having the expertise or experience or willingness to develop the expertise or experience necessary to participate in the Initiative.

C. In developing the consortium, the Commissioner shall ensure that all geographical areas of the Commonwealth are included in the Initiative. To accomplish this goal, the Commissioner shall contact Eastern Virginia Medical School and its participating hospitals, Virginia Commonwealth University School of Medicine, Virginia Commonwealth University Health System, the University of Virginia School of Medicine, the University of Virginia Health System, and other entities located in Virginia, such as hospitals and hospital systems, biotechnology companies, regional blood banks, laboratories, or other health care providers or medical researchers, or local coalitions of health care providers that could provide coverage of the various geographical regions of Virginia, to request their participation in the Initiative consortium and assist in the design and implementation of the Initiative.

D. Any nonprofit entity having an arrangement or contract with the Commissioner for the development of the Initiative and any medical school, hospital, or other health care provider choosing to participate in the Initiative shall submit an estimate of the costs of implementing the Initiative for the region in which it is located. The Commissioner shall assist in the development of the cost estimates, compare and evaluate such estimates, and negotiate with the various entities to implement the Initiative.

Further, the Commissioner shall coordinate (i) appropriate contact with pregnant women to provide information about umbilical cord blood donations; (ii) the development of procedures for obtaining informed consent for cord blood donations; (iii) the design of the Initiative, including the period of years for storage of the cord blood to ensure the integrity of the cells; (iv) a system for recycling the blood at the end of the established storage period that provides for the sale or transfer of the cord blood samples being taken out of storage to be used in basic or clinical research development at reasonable rates and fees for cord blood products.

E. The entities joining the Initiative shall work collaboratively, each with the community resources in its local or regional area. The Initiative participants shall align their outreach programs and activities to all geographic areas and ethnic and racial groups of the Commonwealth, and shall conduct specific and culturally appropriate outreach and research to identify potential donors among all ethnic and racial groups.

F. The Commissioner shall disseminate information about the Initiative, focusing on hospitals, birthing facilities, physicians, midwives, and nurses, and providing information through local health departments.

Initiative consortium participants shall also be encouraged to disseminate information about the Initiative.

In addition, the Director of the Department of Medical Assistance Services shall include information about the Initiative in printed materials distributed by the Department to recipients of medical assistance services and persons enrolled in the Family Access to Medical Insurance Security Plan.

G. Any woman admitted to a hospital or birthing facility for obstetrical services may be offered the opportunity to donate umbilical cord blood to the Initiative. However, no woman shall be required to make a cord blood donation.

H. Any health care facility or health care provider receiving financial remuneration for the collection of umbilical cord blood shall, prior to harvesting the umbilical cord blood, disclose this information in writing to any woman postpartum or to the parent of a newborn from whom the umbilical cord blood is to be collected.

I. This section shall not be construed to require participation in the Initiative on the part of any health care facility or health care provider who objects to transfusion or transplantation of blood on the basis of bona fide religious beliefs.

J. The Initiative shall be implemented with such funds as may be appropriated or otherwise provided for its purpose. Upon implementation, the Commissioner shall initiate the development of a nonprofit entity to assume the operation and administration of the Initiative and may seek federal, state, and private grant funds for its continuation.

2006, cc. 636, 735; 2008, c. 285.

§ 32.1-69.3. (Effective pursuant to Acts 2023, cc. 756 and 778, cl. 5) Virginia Cord Blood Bank Initiative established.

A. There is hereby established the Virginia Cord Blood Bank Initiative (the Initiative) as a public resource for the treatment of patients with life-threatening diseases or debilitating conditions, for use in advancing basic and clinical research, and, in the event of a terrorist attack, to be used in the treatment of the injured.

The Initiative shall be established as a nonprofit legal entity to collect, screen for infectious and genetic diseases, perform tissue typing on, cryopreserve, and store umbilical cord blood as a public resource and shall be formed as a collaborative consortium that covers all geographical regions of Virginia.

B. The State Health Commissioner shall develop or shall arrange for or contract with a nonprofit entity for the development of the collaborative consortium to be known as the Initiative, which may consist of any entity having the expertise or experience or willingness to develop the expertise or experience necessary to participate in the Initiative.

C. In developing the consortium, the Commissioner shall ensure that all geographical areas of the Commonwealth are included in the Initiative. To accomplish this goal, the Commissioner shall contact Eastern Virginia Health Sciences Center at Old Dominion University and its participating hospitals, Virginia Commonwealth University School of Medicine, Virginia Commonwealth University Health System, the University of Virginia School of Medicine, the University of Virginia Health System, and other entities located in Virginia, such as hospitals and hospital systems, biotechnology companies, regional blood banks, laboratories, or other health care providers or medical researchers, or local coalitions of health care providers that could provide coverage of the various geographical regions of Virginia, to request their participation in the Initiative consortium and assist in the design and implementation of the Initiative.

D. Any nonprofit entity having an arrangement or contract with the Commissioner for the development of the Initiative and any medical school, hospital, or other health care provider choosing to participate in the Initiative shall submit an estimate of the costs of implementing the Initiative for the region in which it is located. The Commissioner shall assist in the development of the cost estimates, compare and evaluate such estimates, and negotiate with the various entities to implement the Initiative.

Further, the Commissioner shall coordinate (i) appropriate contact with pregnant women to provide information about umbilical cord blood donations; (ii) the development of procedures for obtaining informed consent for cord blood donations; (iii) the design of the Initiative, including the period of years

for storage of the cord blood to ensure the integrity of the cells; (iv) a system for recycling the blood at the end of the established storage period that provides for the sale or transfer of the cord blood samples being taken out of storage to be used in basic or clinical research development at reasonable rates and fees for cord blood products.

E. The entities joining the Initiative shall work collaboratively, each with the community resources in its local or regional area. The Initiative participants shall align their outreach programs and activities to all geographic areas and ethnic and racial groups of the Commonwealth, and shall conduct specific and culturally appropriate outreach and research to identify potential donors among all ethnic and racial groups.

F. The Commissioner shall disseminate information about the Initiative, focusing on hospitals, birthing facilities, physicians, midwives, and nurses, and providing information through local health departments.

Initiative consortium participants shall also be encouraged to disseminate information about the Initiative.

In addition, the Director of the Department of Medical Assistance Services shall include information about the Initiative in printed materials distributed by the Department to recipients of medical assistance services and persons enrolled in the Family Access to Medical Insurance Security Plan.

G. Any woman admitted to a hospital or birthing facility for obstetrical services may be offered the opportunity to donate umbilical cord blood to the Initiative. However, no woman shall be required to make a cord blood donation.

H. Any health care facility or health care provider receiving financial remuneration for the collection of umbilical cord blood shall, prior to harvesting the umbilical cord blood, disclose this information in writing to any woman postpartum or to the parent of a newborn from whom the umbilical cord blood is to be collected.

I. This section shall not be construed to require participation in the Initiative on the part of any health care facility or health care provider who objects to transfusion or transplantation of blood on the basis of bona fide religious beliefs.

J. The Initiative shall be implemented with such funds as may be appropriated or otherwise provided for its purpose. Upon implementation, the Commissioner shall initiate the development of a nonprofit entity to assume the operation and administration of the Initiative and may seek federal, state, and private grant funds for its continuation.

2006, cc. 636, 735; 2008, c. 285; 2023, cc. 756, 778.

§ 32.1-69.4. Publication of information regarding cord blood education.

In addition to the requirements of § 32.1-69.3, the Commissioner shall make publicly available, by posting on the public website of the Department of Health, resources relating to umbilical cord blood

that have been developed by the Parent's Guide to Cord Blood Foundation and include the following information:

1. An explanation of the potential value and uses of umbilical cord blood, including cord blood cells and stem cells, for individuals who are, as well as individuals who are not, biologically related to a mother or her newborn child.

2. An explanation of the differences between using one's own cord blood cells and using related or unrelated cord blood stem cells in the treatment of disease.

3. An explanation of the differences between public and private umbilical cord blood banking.

4. The options available to a mother relating to stem cells that are contained in the umbilical cord blood after the delivery of her newborn, including (i) donating the stem cells to a public umbilical cord blood bank where facilities are available; (ii) storing the stem cells in a private family umbilical cord blood bank for use by immediate and extended family members; (iii) storing the stem cells for immediate or extended family members through a family or sibling donor banking program that provides free collection, processing, and storage where there is an existing medical need; and (iv) discarding the stem cells.

5. The medical processes involved in the collection of cord blood.

6. Medical or family history criteria that can impact a family's consideration of umbilical cord blood banking, including the likelihood of using a baby's cord blood to serve as a match for a family member who has a medical condition.

7. Options for ownership and future use of donated umbilical cord blood.

8. The average cost of public and private umbilical cord blood banking.

9. The availability of public and private cord blood banks to Virginians, including (i) a list of public cord blood banks and the hospitals served by such banks; (ii) a list of private cord blood banks that are available; and (iii) the availability of free family banking and sibling donor programs where there is an existing medical need by a family member.

10. An explanation of which racial and ethnic groups are in particular need of publicly donated cord blood samples based upon medical data developed by the U.S. Health Resources and Services Administration.

2010, c. 69.

Article 9 - STATEWIDE CANCER REGISTRY

§ 32.1-70. Information from hospitals, clinics, certain laboratories and physicians supplied to Commissioner; statewide cancer registry.

A. Each hospital, clinic and independent pathology laboratory shall make available to the Commissioner or his agents information on patients having malignant tumors or cancers. A physician shall

report information on patients having cancers unless he has determined that a hospital, clinic or in-state pathology laboratory has reported the information. This reporting requirement shall not apply to basal and squamous cell carcinoma of the skin. Such information shall include the name, address, sex, race, diagnosis and any other pertinent identifying information regarding each such patient and shall include information regarding possible exposure to Agent Orange or other defoliants through their development, testing or use or through service in the Vietnam War. Each hospital, clinic, independent pathology laboratory, or physician shall provide other available clinical information as defined by the Board of Health.

B. From such information the Commissioner shall establish and maintain a statewide cancer registry. The purpose of the statewide cancer registry shall include but not be limited to:

1. Determining means of improving the diagnosis and treatment of cancer patients.

2. Determining the need for and means of providing better long-term, follow-up care of cancer patients.

3. Conducting epidemiological analyses of the incidence, prevalence, survival, and risk factors associated with the occurrence of cancer in Virginia.

4. Collecting data to evaluate the possible carcinogenic effects of environmental hazards including exposure to dioxin and the defoliant, Agent Orange.

5. Collecting data to evaluate potential links between exposure to fire incidents and cancer incidence.

6. Improving rehabilitative programs for cancer patients.

7. Assisting in the training of hospital personnel.

8. Determining other needs of cancer patients and health personnel.

Code 1950, § 32-388; 1950, p. 187; 1978, c. 792; 1979, c. 711; 1988, cc. 447, 459, 843; 1998, c. 315; 2018, c. 459.

§ 32.1-70.1. Repealed.

Repealed by Acts 1998, c. 315.

§ 32.1-70.2. Collection of cancer case information by the Commissioner.

A. Using such funds as may be appropriated therefor, the Commissioner or his designee may perform on-site data collection of the records of patients having malignant tumors or cancers at those consenting hospitals, clinics, independent pathology laboratories and physician offices required to report information of such patients pursuant to the reporting requirements of § 32.1-70, in order to ensure the completeness and accuracy of the statewide cancer registry.

B. The selection criteria for determining which consenting hospitals, clinics, independent pathology laboratories and physician offices may be subject to on-site data collection under the provisions of this section shall include, but shall not be limited to: (i) expected annual number of cancer case reports, (ii) historical completeness and accuracy of reporting rates, and (iii) whether the facility maintains its own cancer registry.

C. The Board of Health shall promulgate regulations necessary to implement the provisions of this section.

2000, cc. 74, 139.

§ 32.1-71. Confidential nature of information supplied; publication; reciprocal data-sharing agreements.

A. The Commissioner and all persons to whom information is submitted in accordance with § 32.1-70 shall keep such information confidential. Except as authorized by the Commissioner in accordance with the provisions of § 32.1-41, no release of any such information shall be made except in the form of statistical or other studies which do not identify individual cases.

B. The Commissioner may enter into reciprocal data-sharing agreements with other cancer registries for the exchange of information. Upon the provision of satisfactory assurances for the preservation of the confidentiality of such information, patient-identifying information may be exchanged with other cancer registries which have entered into reciprocal data-sharing agreements with the Commissioner.

Code 1950, § 32-389; 1950, p. 187; 1979, c. 711; 1991, c. 319; 2000, cc. 74, 139.

§ 32.1-71.01. Penalties for unauthorized use of statewide cancer registry.

In addition to the remedies provided in § 32.1-27, any person who uses, discloses or releases data maintained in the statewide cancer registry in violation of § 32.1-71 shall be subject, in the discretion of the court, to a civil penalty not to exceed $25,000 for each violation, which shall be paid to the general fund.

2000, cc. 74, 139.

§ 32.1-71.02. Notification of cancer patients of statewide cancer registry reporting.

A. Any physician diagnosing a malignant tumor or cancer shall, at such time and in such manner as considered appropriate by such physician, notify each patient whose name and record abstract is required to be reported to the statewide cancer registry pursuant to § 32.1-70 that personal identifying information about him has been included in the registry as required by law. Any physician required to so notify a patient that personal identifying information about him has been included in the cancer registry may, when, in the opinion of the physician, such notice would be injurious to the patient's health or well-being, provide the required notice to the patient's authorized representative or next of kin in lieu of notifying the patient.

B. Upon request to the statewide cancer registry, the patient whose personal identifying information has been submitted to such registry shall have a right to know the identity of the reporter of his information to such registry.

2000, c. 918; 2003, cc. 540, 548.

Article 9.1 - Statewide Alzheimer's Disease and Related Disorders Registry

§§ 32.1-71.1 through 32.1-71.4. Repealed.

Repealed by Acts 1994, c. 109.

Article 10 - LABORATORY TESTS

§ 32.1-72. Repealed.

Repealed by Acts 1992, cc. 747 and 873.

Article 11 - PENALTY

§ 32.1-73. Failure to comply with provisions; grounds for revocation of license or permit.

The failure of any physician, nurse or midwife to comply with the provisions of § 32.1-60, § 32.1-62 or § 32.1-65 shall, in addition to any other penalty prescribed by law, constitute grounds for revocation of the license or permit of such physician, nurse or midwife by the board issuing such license or permit.

1979, c. 711.

Article 17 - Substance-Exposed Infants

§ 32.1-73.12. Department to be lead agency for services for substance-exposed infants.

The Department shall serve as the lead agency with responsibility for the development, coordination, and implementation of a plan for services for substance-exposed infants in the Commonwealth. Such plan shall support a trauma-informed approach to identification and treatment of substance-exposed infants and their caregivers and shall include options for improving screening and identification of substance-using pregnant women; use of multidisciplinary approaches to intervention and service delivery during the prenatal period and following the birth of the substance-exposed child; and referral among providers serving substance-exposed infants and their families and caregivers. In carrying out its duties, the Department shall work cooperatively with the Department of Social Services, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, local departments of health, the Virginia Chapter of the American Academy of Pediatrics, the American Congress of Obstetricians and Gynecologists, Virginia Section, and such other stakeholders as may be appropriate. The Department shall report annually on December 1 to the General Assembly regarding implementation of the plan.

2018, cc. 695, 696.

Article 12 - THE COMMONWEALTH NEUROTRAUMA INITIATIVE

§§ 32.1-73.1 through 32.1-73.4. Repealed.

Repealed by Acts 2002, c. 60.

Article 13 - STATEWIDE ASTHMA MANAGEMENT

§ 32.1-73.5. Comprehensive statewide asthma management plan.

A. Using such funds as may be appropriated therefor, the Commissioner shall develop, maintain, and revise biennially a written comprehensive state plan for (i) reducing the rate of hospitalizations due to asthma and (ii) facilitating the effective management of persons with asthma residing in the Commonwealth. The plan shall address, but shall not be limited to, disease surveillance and investigation,

public and professional education, identification and replication of best practices for public health and clinical interventions, public and private partnerships with health care providers, third-party payors, local school divisions, and community coalitions, and identification of sources of grant funding. The plan shall place primary emphasis on, but not be limited to, children between the ages of birth and eighteen years.

B. In order to develop the comprehensive state plan, the Commissioner shall consult with representatives of the medical, nursing, pharmacy and allied health professions, public health agencies, community coalition leaders, insurers, hospital personnel, the Department of Education and local school divisions, and other appropriate entities.

2000, cc. 73, 134.

§ 32.1-73.6. Implementation of state asthma management programs.

A. Using such funds as may be appropriated for this purpose, the Commissioner shall implement programs to meet the objectives of the statewide asthma management plan. The Commissioner shall assure, to the extent feasible and appropriate, that existing Department programs, systems, and infrastructure are efficiently utilized as a basis for implementation.

B. The Board shall promulgate regulations as necessary to implement the provisions of the statewide asthma management plan.

C. The Commissioner shall report periodically to the Board concerning (i) the development and implementation of the statewide asthma management plan and (ii) the effectiveness of the Department programs in reducing the rate of hospitalizations due to asthma in the Commonwealth and facilitating more effective management of asthma.

2000, cc. 73, 134.

Article 14 - YOUTH SUICIDE PREVENTION

§ 32.1-73.7. Department to be lead agency for youth suicide prevention.

With such funds as may be appropriated for this purpose, the Department, in consultation with the Department of Education, the Department of Behavioral Health and Developmental Services, community services boards and behavioral health authorities, and local departments of health, shall have the lead responsibility for the youth suicide prevention program within the Commonwealth. This responsibility includes coordination of the activities of the agencies of the Commonwealth pertaining to youth suicide prevention in order to develop and carry out comprehensive youth suicide prevention strategies addressing public awareness, the promotion of health development, early identification, intervention and treatment, and support to survivors. The strategies shall be targeted to the specific needs of children and adolescents. The Department shall cooperate with federal, state and local agencies, private and public agencies, survivor groups and other interested persons in order to prevent youth suicide within the Commonwealth.

The provisions of this section shall not limit the powers and duties of other state agencies.

2001, cc. 275, 291; 2003, c. 885; 2005, cc. 336, 434; 2009, cc. 813, 840.

Article 15 - YOUTH HEALTH RISK BEHAVIOR SURVEY

§ 32.1-73.8. Youth health risk behavior survey.

The Department shall, in cooperation with the Department of Behavioral Health and Developmental Services and the Superintendent of Public Instruction, develop and administer a survey of students to facilitate planning and implementation of effective programs for the prevention of substance abuse through collection of data and information to (i) identify trends in the use of alcohol, tobacco, and other drugs and (ii) assess the prevalence of risk and protective factors among the youth of the Commonwealth. In developing such survey, the Department may utilize all or part of an existing survey designed to collect such information developed by the Centers for Disease Control and Prevention. The survey shall be anonymous and administered in a manner designed to protect students' privacy. Schools shall be randomly selected for participation in the survey. Schools selected to participate in the survey shall notify students and parents pursuant to § 22.1-79.3. A student whose parents have refused to consent to the student's participation in the survey as provided in § 22.1-79.3 shall not be required to participate in the survey.

2011, c. 726.

Article 16 - Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome

§ 32.1-73.9. Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome; membership.

A. There is hereby created in the executive branch of state government the Advisory Council on Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and Pediatric Acute-onset Neuropsychiatric Syndrome (the Advisory Council), for the purpose of advising the Commissioner of Health on research, diagnosis, treatment, and education relating to pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome.

B. The Advisory Council shall have a total membership of 16 members that shall consist of six legislative members, nine nonlegislative citizen members, and one ex officio member. Members shall be appointed as follows: four members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; two members of the Senate to be appointed by the Senate Committee on Rules; and the following nine nonlegislative citizen members to be appointed by the Governor: one licensed health care provider who has expertise in treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and autism; one pediatrician who has experience treating persons

with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one child psychiatrist who has experience treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one immunologist with experience in treating persons with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and the use of intravenous immunoglobulin; one medical researcher with experience conducting research concerning pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome, obsessive-compulsive disorder, tic disorder, and other neurological disorders; one representative of a professional organization for school nurses in the Commonwealth; one representative of an advocacy and support group for individuals affected by pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; one representative of an advocacy and support group for individuals affected by autism; and one parent of a child who has been diagnosed with pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome and autism. The Commissioner of Health or his designee shall serve ex officio without voting privileges. Nonlegislative members shall be citizens of the Commonwealth.

Legislative members and the ex officio member of the Advisory Council shall serve terms coincident with their terms of office. Nonlegislative members shall be appointed for terms of two years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed.

C. Legislative members of the Advisory Council shall receive such compensation as provided in § 30-19.12. Nonlegislative members shall serve without compensation or reimbursement.

D. The Advisory Council shall elect a chairman and a vice-chairman annually from among its legislative membership. A majority of the members shall constitute a quorum. The Advisory Council shall meet at such times as may be called by the chairman or a majority of the Advisory Council.

E. Staff to the Advisory Council shall be provided by the Department of Health. All agencies of the Commonwealth shall provide assistance to the Advisory Council, upon request.

2017, c. 466.

§ 32.1-73.10. Advisory Council; report.

The Advisory Council shall report to the Governor and the General Assembly, by December 1 of each year, on the Advisory Council's recommendations related to:

1. Practice guidelines for the diagnosis and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome;

2. Mechanisms to increase clinical awareness and education regarding pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset

neuropsychiatric syndrome among physicians, including pediatricians, school-based health centers, and providers of mental health services;

3. Outreach to educators and parents to increase awareness of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome; and

4. Development of a network of volunteer experts on the diagnosis and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute-onset neuropsychiatric syndrome to assist in the delivery of education and outreach.

2017, c. 466.

§ 32.1-73.11. (Continued pursuant to Acts 2022, Sp. S. I, c. 2, item 299 D) Sunset.
This article shall expire on July 1, 2020.

2017, c. 466; 2022, Sp. Sess. 1, c. 2.

Article 18 - Alzheimer's Disease

§ 32.1-73.13. Alzheimer's disease and related dementias; early detection and diagnosis; risk reduction and care planning.
Using such funds as may be available for such purpose, the Department, in consultation with the Department for Aging and Rehabilitative Services, shall have the lead responsibility for (i) educating and informing the public, based on evidence-based public health research and data, about Alzheimer's disease and related dementias; (ii) supporting early detection and diagnosis of Alzheimer's disease and related dementias; (iii) reducing the risk of potentially avoidable hospitalizations for individuals with Alzheimer's disease and related dementias; (iv) reducing the risk of cognitive decline and cognitive impairment associated with Alzheimer's disease and related dementias; and (v) supporting care planning and management for individuals with Alzheimer's disease and related dementias. The Department shall use targeted strategies specific to the needs of persons with Alzheimer's disease and related dementias. The Department shall cooperate with federal, state, and local agencies, private and public agencies, and other interested persons in order to address and reduce the risks and impairments associated with Alzheimer's disease and related dementias within the Commonwealth.

The provisions of this section shall not limit the powers and duties of other state agencies.

2020, c. 854.

Article 19 - Rare Disease Council

§ 32.1-73.14. Rare Disease Council; purpose.
There is hereby created in the executive branch of state government the Rare Disease Council (the Council) for the purpose of (i) advising the Governor and the General Assembly on the needs of individuals with rare diseases in the Commonwealth; (ii) identifying challenges that such individuals face,

including delays in obtaining a diagnosis or the receipt of a misdiagnosis, shortages of medical specialists who can provide treatment, and lack of access to therapies and medication used to treat rare diseases; (iii) funding research related to rare diseases and the development of new treatments for rare diseases; and (iv) funding for supports for persons with rare diseases in the Commonwealth.

2021, Sp. Sess. I, c. 303.

§ 32.1-73.15. Powers and duties of the Council.

The Council shall have the power and duty to:

1. Within the first year, hold public hearings and make inquiries of and solicit comments from the public to assist the Council in understanding the scope of rare diseases in the Commonwealth and the impact of rare diseases on individuals in the Commonwealth.

2. Conduct research and consult with experts to develop policy recommendations related to:

a. Improving access to health care and other services for individuals with rare diseases, including access to health insurance, specialists, health care services, and other necessary services for individuals with rare diseases;

b. The impact of health insurance coverage, cost sharing, tiers, or other utilization management procedures on access to health care and other necessary services; and

c. The impact of providing coverage under the state program for medical assistance services for approved health care services and medications for rare diseases.

3. Publish a list of existing publicly accessible resources on research, diagnosis, treatment, and education relating to rare diseases on the Council's webpage.

4. Submit annually by October 1 a report to the Governor and the General Assembly for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The annual report shall (i) describe the activities and recommendations of the Council and (ii) describe the status of funding available to the Council, including information regarding any grants applied for and received by the Council.

5. Apply for, accept, and expend gifts, grants, and donations from public or private sources to enable the Council to better carry out its objectives.

2021, Sp. Sess. I, c. 303.

§ 32.1-73.16. Membership; terms; quorum; meetings; staffing.

A. The Council shall have a total membership of 21 members that shall consist of 18 nonlegislative citizen members and three ex officio members. The Governor shall appoint a chairman and vice-chairman who shall be residents of the Commonwealth and shall not be employed by any federal or state government. Nonlegislative citizen members shall be appointed by the Governor and shall include, in addition to the chairman and the vice-chairman, one representative from an academic research institution in the Commonwealth that receives any grant funding for rare disease research; one geneticist

licensed and currently practicing in the Commonwealth; one registered nurse or advanced practice registered nurse licensed and currently practicing in the Commonwealth, with experience in treating rare diseases; two physicians with expertise in rare diseases who are licensed and currently practicing medicine in the Commonwealth; one hospital administrator, or his designee, from a hospital in the Commonwealth that provides care to persons diagnosed with rare diseases; two persons who are 18 years of age or older who have been diagnosed with a rare disease; two caregivers of persons with a rare disease; two representatives of rare disease patient organizations operating in the Commonwealth; one licensed pharmacist with experience with drugs used to treat rare diseases; one representative from the biopharmaceutical industry; one representative from health plan companies; and one member from the scientific community who is engaged in rare disease research, which may include a medical researcher with experience conducting research on rare diseases. The Commissioner of Health, the Director of the Department of Medical Assistance Services, and the Superintendent of Public Instruction, or their designees, shall serve ex officio with nonvoting privileges. Ex officio members of the Council shall serve terms coincident with their terms of office.

Nonlegislative citizen members of the Council shall be citizens of the Commonwealth. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of three years.

Ex officio members of the Council shall serve terms coincident with their terms of office. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years.

B. The Council shall meet quarterly and the chairman and vice-chairman shall establish a meeting schedule on an annual basis. A majority of the members shall constitute a quorum.

C. Members of the Council shall serve without compensation or reimbursement.

D. The Department of Health shall provide staff support to the Council. All agencies of the Commonwealth shall provide assistance to the Council, upon request.

2021, Sp. Sess. I, c. 303.

§ 32.1-73.17. Rare Disease Council Fund.

There is hereby created in the state treasury a special nonreverting fund to be known as the Rare Disease Council Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All funds appropriated for such purpose and any gifts, grants, donations, and other funds received on its behalf shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purpose of (i) funding research related to rare diseases and the development of new treatments for rare diseases

and supports for persons with rare diseases in the Commonwealth and (ii) supporting the work of the Council. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner of Health.

2021, Sp. Sess. I, c. 303.

Article 20 - Renal Disease Council

§ 32.1-73.18. Renal Disease Council; purpose.

There is hereby created in the executive branch of state government the Renal Disease Council (the Council) for the purpose of (i) advising the Governor and the General Assembly on the needs of individuals with renal disease in the Commonwealth; (ii) identifying challenges that such individuals face and making recommendations for the improvement of the Commonwealth's kidney care system, particularly related to care coordination and prevention; (iii) funding research related to renal disease; (iv) funding supports for persons with renal disease in the Commonwealth; and (v) developing programs to educate medical professionals and the public about renal disease.

2022, c. 717.

§ 32.1-73.19. Powers and duties of the Council.

The Council shall have the power and duty to:

1. Within the first year, hold public hearings and make inquiries of and solicit comments from the public to assist the Council in understanding the scope of the challenges related to renal disease in the Commonwealth and the impact of renal disease on individuals in the Commonwealth.

2. Conduct research and consult with experts to develop policy recommendations related to:

a. Improving access to health care and other services for individuals with renal disease, including access to health insurance, specialists, health care services, and other necessary services for individuals with renal disease;

b. The impact of health insurance coverage, cost-sharing, tiers, or other utilization management procedures on access to health care and other necessary services; and

c. The impact of providing coverage under the state program for medical assistance services for approved health care services and medications for renal disease.

3. Publish a list of existing publicly accessible resources on research, diagnosis, treatment, and education relating to renal disease on the Council's webpage.

4. Submit annually by October 1 a report to the Governor and the General Assembly for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports. The annual report shall (i) describe the activities and recommendations of the Council and (ii) describe the status of funding available to the Council, including information regarding any grants applied for and received by the Council.

5. Apply for, accept, and expend gifts, grants, and donations from public or private sources to enable the Council to better carry out its objectives.

2022, c. 717.

§ 32.1-73.20. Membership; terms; quorum; meetings; staffing.

A. The Council shall have a total membership of 21 members that shall consist of 18 nonlegislative citizen members and three ex officio members. The Governor shall appoint a chairman and vice-chairman who shall be residents of the Commonwealth and shall not be employed by any federal or state government. Nonlegislative citizen members shall be appointed by the Governor and shall include, in addition to the chairman and the vice-chairman, one representative from an academic research institution in the Commonwealth that receives any grant funding for renal disease research; one registered nurse or advanced practice registered nurse licensed and currently practicing in the Commonwealth with experience in treating renal disease; two physicians with expertise in renal disease who are licensed and currently practicing medicine in the Commonwealth; one hospital administrator, or his designee, from a hospital in the Commonwealth that provides care to persons diagnosed with renal disease; one person who is a dialysis social worker; two persons who are 18 years of age or older who have been diagnosed with a renal disease; two caregivers of persons with renal disease; two representatives of renal disease patient organizations operating in the Commonwealth; one licensed pharmacist with experience with drugs used to treat renal disease; one representative from the biopharmaceutical industry; one representative from health plan companies; and one member from the scientific community who is engaged in renal disease research, which may include a medical researcher with experience conducting research on renal disease. The Commissioner of Health, the Director of the Department of Medical Assistance Services, and the Director of the Department of Health Professions, or their designees, shall serve ex officio with nonvoting privileges.

Nonlegislative citizen members of the Council shall be citizens of the Commonwealth. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years.

Ex officio members of the Council shall serve terms coincident with their terms of office.

Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

B. The Council shall meet quarterly and the chairman and vice-chairman shall establish a meeting schedule on an annual basis. A majority of the members shall constitute a quorum.

C. Members of the Council shall serve without compensation or reimbursement.

D. The Department of Health shall provide staff support to the Council. All agencies of the Commonwealth shall provide assistance to the Council, upon request.

2022, c. 717.

Chapter 3 - MEDICAL CARE SERVICES

Article 1 - MEDICAL ASSISTANCE PROGRAM

§§ 32.1-74 through 32.1-76. Repealed.

Repealed by Acts 1984, c. 781, effective March 1, 1985.

§ 32.1-76.1. Repealed.

Repealed by Acts 1984, c. 629.

§§ 32.1-76.2, 32.1-76.3. Repealed.

Repealed by Acts 1984, c. 781, effective March 1, 1985.

Article 2 - MATERNAL AND CHILD HEALTH SERVICES AND CRIPPLED CHILDREN'S SERVICES

§ 32.1-77. State plans for maternal and child health services and children's specialty services.

A. The Board is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services, state plans for maternal and child health services and children's specialty services pursuant to Title V of the United States Social Security Act and any amendments thereto.

B. The Commissioner is authorized to administer such plans and to receive and expend federal funds for the administration thereof in accordance with applicable federal and state laws and regulations.

Code 1950, § 32-165; 1979, c. 711; 1987, c. 427.

§ 32.1-77.1. State-certified doulas; certification.

A. As used in this section, "state-certified doula" means a trained, community-based nonmedical professional who provides continuous physical, emotional, and informational support to a pregnant person during the antepartum or intrapartum period or during the period up to one year postpartum and who has been certified by a body approved by the Board for such purpose in accordance with the provisions of this section.

B. No person shall use or assume the title "state-certified doula" unless such person is a community-based doula who (i) has received training and education as a doula from an entity approved by a body approved by the Board for such purpose and (ii) has been certified as a doula by a body approved by the Board for such purpose.

C. No entity shall hold itself out as providing training and education necessary to meet the requirements of clause (i) of subsection B unless its curriculum and training program has been approved by a body approved by the Board for such purpose.

D. The Board shall adopt regulations setting forth the requirements for (i) use of the title "state-certified doula" and (ii) training and education necessary to satisfy the requirements for certification by the Department as a state-certified doula.

E. Notwithstanding the provisions of subsection B, a person who is certified by a national credentialing organization that is approved by a body approved by the Board for such purpose who does not meet the requirements of clause (i) of subsection B shall also be eligible for state certification.

F. Certification requirements for state-certified doulas shall reflect national best practices pertaining to community-based doula training and certification.

G. The Department shall make a registry of state-certified doulas in the Commonwealth available to the public through a body approved by the Board to certify doulas. The Department shall also make a list of entities approved to provide training and education necessary to meet the requirements of clause (i) of subsection B available to the public through a body approved by the Board to certify doulas.

H. Nothing in this section shall prohibit any person from practicing as a doula in the Commonwealth, regardless of whether such person is certified in accordance with the provisions of this section.

2020, c. 724.

§ 32.1-78. Reporting information about children with health problems or disabilities.
Notwithstanding § 32.1-271 or any other law to the contrary, the Commissioner shall report to the Superintendent of Public Instruction or to the appropriate school division superintendent within the Commonwealth the identity of, and pertinent information about, children with health problems or disabilities that might affect the child's career in school and his need for special education.

Code 1950, § 32-11.1; 1972, c. 431; 1979, c. 711; 2023, cc. 148, 149.

Article 3 - VIRGINIA VOLUNTARY FORMULARY

§§ 32.1-79 through 32.1-88. Repealed.
Repealed by Acts 2003, c. 639, cl. 2.

Article 4 - MISCELLANEOUS SERVICES

§ 32.1-89. Health services for persons suffering from hemophilia and related diseases.
A. The State Board of Health shall establish a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases who are unable to pay for the entire cost of such services on a continuing basis despite the existence of various types of hospital and medical insurance. The program may include (i) payments on behalf of such persons for obtaining blood, blood derivatives and concentrates, for necessary medical, surgical, dental, hospital and outpatient clinic services and for rehabilitation; (ii) the establishment of, or contracts for, hospital and clinic facilities for the diagnosis and treatment of such persons; (iii) participation in the cost of blood processing to the extent that such participation will facilitate the supplying of blood, blood derivatives and concentrates and other efficacious agents to such persons; and (iv) development of, or participation in the cost of developing, programs for the care and treatment of such persons, including self-administration, prevention

and home care and medical and dental procedures and techniques designed to provide maximum control over bleeding episodes typical in such persons.

B. The State Board of Health may provide home and clinic health services for persons suffering from hemophilia or other related bleeding diseases who are not eligible under subsection A. The State Board of Health may provide such services through cooperative agreements with medical facilities or other appropriate means. Charges for persons receiving care or treatment under this subsection shall be determined by the State Board of Health. Funds received in payment for such services are hereby appropriated to the State Board of Health for the purpose of carrying out the provisions of this section.

C. The State Board of Health shall provide for the development, implementation, and sustainability of a process for the receipt and consideration of advice and policy recommendations at least annually from, and on behalf of, persons suffering from hemophilia and other related bleeding diseases, for the purpose of informing programs and services established under this section.

Code 1950, § 32-8.6; 1976, c. 296; 1979, c. 711; 1985, c. 448; 2002, c. 696; 2012, cc. 803, 835.

§ 32.1-90. Health services for persons suffering from epilepsy and cystic fibrosis.

The Board may provide, through cooperative agreements with medical facilities or other appropriate means, home and clinic health services for persons suffering from epilepsy and for persons not eligible for child supportive services suffering from cystic fibrosis. Monetary payments from persons for care or treatment under this section shall be determined by the Board. Funds received in payment for such services are hereby appropriated to the Board for the purpose of carrying out the provisions of this section.

Code 1950, §§ 32-8.3; 32-8.4; 1974, c. 562; 1975, c. 294; 1979, c. 711.

§ 32.1-91. Repealed.

Repealed by Acts 1980, c. 728.

§ 32.1-92. Repealed.

Repealed by Acts 1982, c. 15.

§ 32.1-92.1. Funding of certain abortions where pregnancy results from rape or incest.

From the moneys appropriated to the Department from the general fund, the Board shall fund abortions for women who otherwise meet the financial eligibility criteria of the State Medical Assistance Plan in any case in which a pregnancy occurs as a result of rape or incest and which is reported to a law-enforcement or public health agency.

1982, c. 644.

§ 32.1-92.2. Funding of certain abortions where fetus is believed to have incapacitating physical deformity or mental deficiency; physician's certificate.

From the moneys appropriated to the Department from the general fund, the Board shall fund abortions for women who otherwise meet the financial eligibility criteria of the State Medical Assistance Plan in any case in which a physician who is trained and qualified to perform such tests certifies in

writing, after appropriate tests have been performed, that he believes the fetus will be born with a gross and totally incapacitating physical deformity or with a gross and totally incapacitating mental deficiency.

1982, c. 645.

Chapter 4 - Health Care Planning

Article 1 - MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED

§§ 32.1-93 through 32.1-102. Repealed.

Repealed by Acts 1982, c. 388.

Article 1.1 - Medical Care Facilities Certificate of Public Need

§ 32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Application" means a prescribed format for the presentation of data and information deemed necessary by the Board to determine a public need for a project.

"Bad debt" means revenue amounts deemed uncollectable as determined after collection efforts based upon sound credit and collection policies.

"Certificate" means a certificate of public need for a project required by this article.

"Charity care" means health care services delivered to a patient who has a family income at or below 200 percent of the federal poverty level and for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person. "Charity care" does not include care provided for a fee subsequently deemed uncollectable as bad debt. For a nursing home as defined in § 32.1-123, "charity care" means care at a reduced rate to indigent persons.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Project" means any action described in subsection B of § 32.1-102.1:3.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Health Services Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3; (ii) statistical information on the availability of each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3; and (iii) procedures, criteria, and standards for review of applications for projects for each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3.

1982, c. 388; 1983, c. 533; 1984, c. 740; 1985, c. 513; 1989, c. 517; 1991, c. 561; 1992, c. 612; 1993, c. 704; 1995, c. 524; 1996, c. 1050; 1997, c. 600; 1998, c. 289; 1999, cc. 899, 920, 922; 2000, cc. 850, 920; 2004, c. 75; 2007, c. 502; 2008, c. 664; 2009, cc. 67, 175, 813, 840; 2011, cc. 92, 150; 2012, cc. 476, 492, 507, 803, 835; 2015, cc. 541, 542, 651; 2017, cc. 458, 791; 2020, c. 1271.

§ 32.1-102.1:1. Equipment registration required.

Within thirty calendar days of becoming contractually obligated to acquire any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, or other specialized service designated by the Board by regulation, any person shall register such purchase with the Commissioner and the appropriate regional health planning agency.

1999, cc. 899, 922; 2000, c. 931; 2009, c. 175.

§ 32.1-102.1:2. Certificate of public need required; registration of certain equipment and capital projects required.

A. No person shall undertake a project described in subsection B of § 32.1-102.1:3 or regulations of the Board at or on behalf of a medical care facility described in subsection A of § 32.1-102.1:3 without first obtaining a certificate from the Commissioner.

B. No person shall acquire any replacement medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, proton beam therapy, or other specialized service designated by the Board by regulation without first registering such purchase with the Commissioner and the appropriate regional health planning agency. Such registration shall be made at least 30 calendar days prior to the date on which the person will become contractually obligated to acquire such medical equipment.

C. No general hospital shall make any capital expenditure of $5 million or more and no medical care facility other than a general hospital shall make any capital expenditure between $5 million and the

amount established by the Board as the minimum capital expenditure by a medical care facility other than a general hospital for which a certificate is required pursuant to subdivision B 8 of § 32.1-102.1:3 without first registering such capital expenditure with the Commissioner pursuant to regulations of the Board. The amounts specified in this subsection shall be revised annually to reflect inflation using appropriate measures incorporating construction costs and medical inflation.

2020, c. 1271.

§ 32.1-102.1:3. Medical care facilities and projects for which a certificate is required.

A. The following medical care facilities shall be subject to the provisions of this article:

1. Any facility licensed as a hospital, as defined in § 32.1-123;

2. Any hospital licensed as a provider by the Department of Behavioral Health and Developmental Services in accordance with Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2;

3. Any facility licensed as a nursing home, as defined in § 32.1-123;

4. Any intermediate care facility established primarily for the medical, psychiatric, or psychological treatment and rehabilitation of individuals with substance abuse licensed by the Department of Behavioral Health and Developmental Services in accordance with Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2;

5. Any intermediate care facility for individuals with developmental disabilities other than an intermediate care facility established for individuals with intellectual disability (ICF/IID) that has not more than 12 beds and is in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services; and

6. Any specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or proton beam therapy.

B. The following actions undertaken by or on behalf of a medical care facility described in subsection A shall constitute a project for which a certificate of public need is required pursuant to subsection A of § 32.1-102.1:2:

1. Establishment of a medical care facility described in subsection A;

2. An increase in the total number of beds or operating rooms in an existing medical care facility described in subsection A;

3. Relocation of beds from an existing medical care facility described in subsection A to another existing medical care facility described in subsection A;

4. Addition of any new nursing home service at an existing medical care facility described in subsection A;

5. Introduction into an existing medical care facility described in subsection A of any cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), medical rehabilitation, neonatal special care, open heart surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, proton beam therapy, or substance abuse treatment when such medical care facility has not provided such service in the previous 12 months;

6. Conversion of beds in an existing medical care facility described in subsection A to medical rehabilitation beds or psychiatric beds;

7. The addition by an existing medical care facility described in subsection A of any new medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or proton beam therapy, other than new medical equipment for the provision of such service added to replace existing medical equipment for the provision of such service;

8. Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7, by or on behalf of a medical care facility described in subsection A other than a general hospital. The amounts specified in this subdivision shall be revised annually to reflect inflation using appropriate measures incorporating construction costs and medical inflation. Nothing in this subdivision shall be construed to modify or eliminate the reviewability of any project described in subdivisions 1 through 7 when undertaken by or on behalf of a general hospital; and

9. Conversion in an existing medical care facility described in subsection A of psychiatric inpatient beds approved pursuant to a Request for Applications (RFA) to nonpsychiatric inpatient beds.

C. Notwithstanding the provisions of subsection A, any nursing home affiliated with a facility that, on January 1, 1982, and thereafter, (i) is operated as a nonprofit institution, (ii) is licensed jointly by the Department as a nursing home and by the Department of Social Services as an assisted living facility, and (iii) restricts admissions such that (a) admissions to the facility are only allowed pursuant to the terms of a "life care contract" guaranteeing that the full complement of services offered by the facility is available to the resident as and when needed, (b) admissions to the assisted living facility unit of the facility are restricted to individuals defined as ambulatory by the Department of Social Services, and (c) admissions to the nursing home unit of the facility are restricted to those individuals who are res-

idents of the assisted living facility unit of the facility shall not be subject to the requirements of this article.

D. Notwithstanding the provisions of subsection B, a certificate of public need shall not be required for the following actions undertaken by or on behalf of a medical care facility described in subsection A:

1. Relocation of up to 10 beds or 10 percent of the beds, whichever is less, (i) from one existing medical care facility described in subsection A to another existing medical care facility described in subsection A at the same site in any two-year period or (ii) in any three-year period, from one existing medical care facility described in subsection A licensed as a nursing home to any other existing medical care facility described in subsection A licensed as a nursing home that is owned or controlled by the same person and located either within the same planning district or within another planning district out of which, during or prior to that three-year period, at least 10 times that number of beds have been authorized by statute to be relocated from one or more medical care facilities described in subsection A located in that other planning district, and at least half of those beds have not been replaced; or

2. Use of up to 10 percent of beds as nursing home beds by a medical care facility described in subsection A licensed as a hospital, as provided in § 32.1-132.

E. The Department shall regularly review the types of medical care facilities subject to the provisions of this article and projects for which a certificate is required and provide to the Governor and the General Assembly, at least once every five years, a recommendation related to the continued appropriateness of requiring such types of medical care facilities to be subject to the provisions of this article and such types of projects to be subject to the requirement of a certificate. In developing such recommendations, the Department shall consider, for each type of medical care facility and project, the following criteria:

1. The current and projected future availability of the specific type of medical care facility or project;

2. The current and projected future demand for the specific type of medical care facility or project;

3. The current and projected future rate of utilization of the specific type of medical care facility or project;

4. The current and projected future capacity of existing medical care facilities or projects of that specific type;

5. The anticipated impact of changes in population and demographics, reimbursement structures and rates, and technology on demand for and availability, utilization, and capacity of existing medical care facilities or projects of that specific type;

6. Existing quality, utilization, and other controls applicable to the specific type of medical care facility or project; and

7. Any risk to the health or well-being of the public resulting from inclusion of the specific type of medical care facility or project on such list.

2020, c. 1271.

§ 32.1-102.2. Regulations.

A. The Board shall promulgate regulations that are consistent with this article and:

1. Shall establish concise procedures for the prompt review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects. In any structured batching process established by the Board, applications, combined or separate, for computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, and proton beam therapy shall be considered in the radiation therapy batch. A single application may be filed for a combination of (i) radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, and proton beam therapy and (ii) any or all of the computed tomographic (CT) scanning, magnetic resonance imaging (MRI), and positron emission tomographic (PET) scanning;

2. May classify projects and may eliminate one or more or all of the procedures prescribed in § 32.1-102.6 for different classifications;

3. May provide for exempting from the requirement of a certificate projects determined by the Commissioner, upon application for exemption, to be subject to the economic forces of a competitive market or to have no discernible impact on the cost or quality of health services;

4. May establish a schedule of fees for applications for certificates or registration of a project to be applied to expenses for the administration and operation of the Certificate of Public Need Program;

5. Shall establish an expedited application and review process for any certificate for projects reviewable pursuant to subdivision B 8 of § 32.1-102.1:3. Regulations establishing the expedited application and review procedure shall include provisions for notice and opportunity for public comment on the application for a certificate, and criteria pursuant to which an application that would normally undergo the review process would instead undergo the full certificate of public need review process set forth in § 32.1-102.6;

6. Shall establish an exemption from the requirement for a certificate for a project involving a temporary increase in the total number of beds in an existing hospital or nursing home, including a temporary increase in the total number of beds resulting from the addition of beds at a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period

of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health; and

7. Shall require every medical care facility subject to the requirements of this article, other than a nursing home, that is not a medical care facility for which a certificate with conditions imposed pursuant to subsection B of § 32.1-102.4 has been issued and that provides charity care, as defined in § 32.1-102.1, to annually report the amount of charity care provided.

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations. However, the Commissioner may approve a significant change in cost for an approved project that exceeds the authorized capital expenditure by more than 20 percent, provided the applicant has demonstrated that the cost increases are reasonable and necessary under all the circumstances and do not result from any material expansion of the project as approved.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of charity care to indigent persons or accept patients requiring specialized care. Such regulations shall include a methodology and formulas for uniform application of, active measuring and monitoring of compliance with, and approval of alternative plans for satisfaction of such conditions. In addition, the Board's licensure regulations shall direct the Commissioner to condition the issuing or renewing of any license for any applicant whose certificate was approved upon such condition on whether such applicant has complied with any agreement to provide a level of charity care to indigent persons or accept patients requiring specialized care. Except in the case of nursing homes, the value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

D. The Board shall also promulgate regulations to require the registration of a project; for introduction into an existing medical care facility of any new lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, obstetrical, or nuclear imaging services that the facility has never provided or has not provided in the previous 12 months; and for the addition by an existing medical care facility of any medical equipment for lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or nuclear imaging services. Replacement of existing equipment for lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external

beam radiation therapy, or nuclear imaging services shall not require registration. Such regulations shall include provisions for (i) establishing the agreement of the applicant to provide a level of care in services or funds that matches the average percentage of indigent care provided in the appropriate health planning region and to participate in Medicaid at a reduced rate to indigents, (ii) obtaining accreditation from a nationally recognized accrediting organization approved by the Board for the purpose of quality assurance, and (iii) reporting utilization and other data required by the Board to monitor and evaluate effects on health planning and availability of health care services in the Commonwealth.

1982, c. 388; 1991, c. 561; 1993, c. 704; 1996, c. 1050; 1999, cc. 899, 922, 926; 2003, cc. 61, 72; 2007, c. 502; 2009, c. 175; 2017, c. 791; 2019, cc. 136, 343, 839; 2020, c. 1271; 2022, cc. 712, 772.

§ 32.1-102.2:1. State Health Services Plan; Task Force.

A. The Board shall appoint and convene a State Health Services Plan Task Force for the purpose of advising the Board on the content of the State Health Services Plan. The Task Force shall provide recommendations related to (i) periodic revisions to the State Health Services Plan, (ii) specific objective standards of review for each type of medical care facility or project type for which a certificate of public need is required, (iii) project types that are generally noncontested and present limited health planning impacts, (iv) whether certain projects should be subject to expedited review rather than the full review process, and (v) improvements in the certificate of public need process. All such recommendations shall be developed in accordance with an analytical framework established by the Commissioner that includes a specific evaluation of whether State Health Services Plan standards are consistent with the goals of (a) meeting the health care needs of the indigent and uninsured citizens of the Commonwealth, (b) protecting the public health and safety of the citizens of the Commonwealth, (c) promoting the teaching missions of academic medical centers and private teaching hospitals, and (d) ensuring the availability of essential health care services in the Commonwealth, and are aligned with the goals and metrics of the Commonwealth's State Health Improvement Plan.

B. The Task Force shall consist of no fewer than 19 individuals appointed by the Commissioner who are broadly representative of the interests of all residents of the Commonwealth and of the various geographic regions, including two representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Health Care Association, and physicians or administrators representing teaching hospitals affiliated with a public institution of higher education; one representative each of the Virginia Association of Health Plans, the Virginia Association of Free and Charitable Clinics, the Virginia Community Healthcare Association, LeadingAge Virginia, a company that is self-insured or full-insured for health coverage, a nonprofit organization located in the Commonwealth that engages in addressing access to health coverage for low-income individuals, and a rural locality recognized as a medically underserved area; one individual with experience in health facilities planning; and such other individuals as the Commissioner determines is appropriate.

C. The powers and duties of the Task Force shall be:

1. To develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan for adoption by the Board that includes (i) specific formulas for projecting need for medical care facilities and services subject to the requirement to obtain a certificate of public need, (ii) current statistical information on the availability of medical care facilities and services, (iii) objective criteria and standards for review of applications for projects for medical care facilities and services, and (iv) methodologies for integrating the goals and metrics of the State Health Improvement Plan established by the Commissioner into the criteria and standards for review. Criteria and standards for review included in the State Health Services Plan shall take into account current data on drive times, utilization, availability of competing services, and patient choice within and among localities included in the health planning district or region; changes and availability of new technology; and other relevant factors identified by the Task Force. The State Health Services Plan shall also include specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas and providing for weighted calculations of need based on the barriers to health care access in such rural areas in lieu of the determinations of need used for the particular proposed project within the relevant health planning district or region as a whole;

2. To engage the services of private consultants or request the Department to contract with any private organization for professional and technical assistance and advice or other services to assist the Task Force in carrying out its duties and functions pursuant to this section. The Task Force may also solicit the input of experts with professional competence in the subject matter of the State Health Services Plan, including (i) representatives of licensed health care providers or health care provider organizations owning or operating licensed health facilities and (ii) representatives of organizations concerned with health care consumers and the purchasers and payers of health care services; and

3. To review annually and, if necessary, develop recommendations for revisions to each section of the State Health Services Plan on a rotating schedule defined by the Task Force at least every two years following the last date of adoption by the Board.

D. The Task Force shall exercise its powers and carry out its duties to ensure:

1. The availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in the Commonwealth, competitive markets, and patient choice;

2. Appropriate differential consideration of the health care needs of residents in rural localities in ways that do not compromise the quality and affordability of health care services for those residents;

3. Elimination of barriers to access to care and introduction and availability of new technologies and care delivery models that result in greater integration and coordination of care, reduction in costs, and improvements in quality; and

4. Compliance with the goals of the State Health Services Plan and improvement in population health.

E. The Department shall post on its website information regarding the process by which the State Health Services Plan is created and the process by which the Department determines whether a proposed project complies with the State Health Services Plan on its website.

2008, c. 501; 2009, c. 175; 2020, c. 1271.

§ 32.1-102.3. Demonstration of public need required; criteria for determining need.

A. No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated. If it is determined that a public need exists for only a portion of a project, a certificate may be issued for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Health Services Plan; however, if the Commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan. In cases in which a provision of the State Health Services Plan has been previously set aside by the Commissioner and relevant amendments to the Plan have not yet taken effect, the Commissioner's decision shall be consistent with the applicable portions of the State Health Services Plan that have not been set aside and the remaining considerations in subsection B.

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The extent to which the proposed project will provide or increase access to health care services for people in the area to be served and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;

2. The extent to which the proposed project will meet the needs of people in the area to be served, as demonstrated by each of the following: (i) the level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served; (ii) the availability of reasonable alternatives to the proposed project that would meet the needs of people in the area to be served in a less costly, more efficient, or more effective manner; (iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6; (iv) any costs and benefits of the proposed project; (v) the financial accessibility of the proposed project to people in the area to be served, including indigent people; and (vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project;

3. The extent to which the proposed project is consistent with the State Health Services Plan;

4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

6. The feasibility of the proposed project, including the financial benefits of the proposed project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate; and

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care services for citizens of the Commonwealth, including indigent or underserved populations.

1982, c. 388; 1984, c. 740; 1993, c. 704; 1999, c. 926; 2000, c. 931; 2004, cc. 71, 95; 2008, c. 292; 2009, c. 175; 2020, cc. 227, 558, 1271.

§ 32.1-102.3:1. Application for certificate not required of certain nursing facilities or nursing homes. An application for a certificate that there exists a public need for a proposed project shall not be required for nursing facilities or nursing homes affiliated with facilities which, on January 1, 1982, and thereafter, meet all of the following criteria:

1. A facility which is operated as a nonprofit institution.

2. A facility which is licensed jointly by the Department as a nursing facility or nursing home and by the Department of Social Services as an assisted living facility.

3. A facility which observes the following restrictions on admissions:

a. Admissions are only allowed pursuant to the terms of a "life care contract" guaranteeing that the full complement of services offered by the facility is available to the resident as and when needed;

b. Admissions to the assisted living facility unit are restricted to individuals defined as ambulatory by the Department of Social Services;

c. Admissions to the nursing facility or nursing home unit are restricted to those individuals who are residents of the assisted living facility unit.

1982, c. 659; 1993, cc. 957, 993; 2008, c. 857; 2009, c. 175; 2011, c. 155.

§ 32.1-102.3:1.1. Continuing care retirement communities accessing medical assistance.

A. A nursing facility in Planning District 8 in a continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, which is not already certified for participation in the Medical Assistance Program, may be certified for participation in the Medical Assistance Program, without regard to any condition of a certificate of public need, so long as:

1. The nursing facility is no longer operating under an open admissions period;

2. Any residents who qualify and receive medical assistance under the state program must have been residents of the continuing care retirement community for at least three years;

3. Not more than 25 percent of the nursing home beds of the facility, or 15 nursing home beds, whichever is fewer, may be occupied by individuals receiving benefits at any given time; and

4. Any resident who qualifies for and receives medical assistance under the state program in a continuing care retirement community nursing facility must have first exhausted any refundable entrance fee paid on the resident's behalf, as defined in § 38.2-4900, as a result of expenditures for that resident's care in the continuing care retirement community.

B. Nothing in this section shall alter the conditions of a continuing care retirement community's participation in the Medical Assistance Program if that continuing care retirement community was certified for participation prior to July 1, 2010.

For the purposes of this section, "open admissions period" means a time during which a facility may take admissions directly into its nursing home beds without the signing of a standard contract.

2008, c. 857; 2011, c. 155; 2019, cc. 299, 384.

§ 32.1-102.3:2. Certificates of public need; applications to be filed in response to Requests for Applications (RFAs).

A. Except for applications for continuing care retirement community nursing home bed projects filed by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 which comply with the requirements established in this section, the Commissioner shall approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article only in response to Requests for Applications (RFAs) for any project which would result in an increase in the number of beds in a planning district in which nursing facility or extended care services are provided, except as provided in § 32.1-102.3:7.

B. The Board shall adopt regulations establishing standards for the approval and issuance of Requests for Applications by the Commissioner. The standards shall include, but shall not be limited to, a requirement that determinations of need take into account any limitations on access to existing nursing home beds in the planning districts. The RFAs, which shall be published at least annually, shall be jointly developed by the Department and the Department of Medical Assistance Services. RFAs shall be based on analyses of the need, or lack thereof, for increases in the nursing home bed

supply in each of the Commonwealth's planning districts in accordance with standards adopted by the Board by regulation. The Commissioner shall only accept for review applications in response to such RFAs which conform with the geographic and bed need determinations of the specific RFA.

C. Sixty days prior to the Commissioner's approval and issuance of any RFA, the Board shall publish the proposed RFA in the Virginia Register for public comment together with an explanation of (i) the regulatory basis for the planning district bed needs set forth in the RFA and (ii) the rationale for the RFA's planning district designations. Any person objecting to the contents of the proposed RFA may notify, within 14 days of the publication, the Board and the Commissioner of his objection and the objection's regulatory basis. The Commissioner shall prepare, and deliver by registered mail, a written response to each such objection within two weeks of the date of receiving the objection. The objector may file a rebuttal to the Commissioner's response in writing within five days of receiving the Commissioner's response. If objections are received, the Board may, after considering the provisions of the RFA, any objections, the Commissioner's responses, and if filed, any written rebuttals of the Commissioner's responses, hold a public hearing to receive comments on the specific RFA. Prior to making a decision on the RFA, the Commissioner shall consider any recommendations made by the Board.

D. Except for a continuing care retirement community applying for a certificate of public need pursuant to provisions of subsections A, B, and C, applications for continuing care retirement community nursing home bed projects shall be accepted by the Commissioner only if the following criteria are met: (i) the facility is registered with the State Corporation Commission as a continuing care provider pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, (ii) the number of new nursing home beds requested in the initial application does not exceed the lesser of 20 percent of the continuing care retirement community's total number of beds that are not nursing home beds or 60 beds, (iii) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20 percent of its total number of beds that are not nursing home beds, and (iv) the continuing care retirement community has established a qualified resident assistance policy.

E. The Commissioner may approve an initial certificate of public need for nursing home beds in a continuing care retirement community not to exceed the lesser of 60 beds or 20 percent of the total number of beds that are not nursing home beds which authorizes an initial one-time, three-year open admission period during which the continuing care retirement community may accept direct admissions into its nursing home beds. The Commissioner may approve a certificate of public need for nursing home beds in a continuing care retirement community in addition to those nursing home beds requested for the initial one-time, three-year open admission period if (i) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20 percent of its total number of beds that are not nursing beds, (ii) the number of licensed nursing home beds within the continuing care retirement community does not and will not exceed 20 percent of the number of occupied beds that are not

nursing beds, and (iii) no open-admission period is allowed for these nursing home beds. Upon the expiration of any initial one-time, three-year open admission period, a continuing care retirement community which has obtained a certificate of public need for a nursing facility project pursuant to subsection D may admit into its nursing home beds (a) a standard contract holder who has been a bona fide resident of the non-nursing home portion of the continuing care retirement community for at least 30 days, (b) a person who is a standard contract holder who has lived in the non-nursing home portion of the continuing care retirement community for less than 30 days but who requires nursing home care due to change in health status since admission to the continuing care retirement community, (c) a person who is a family member of a standard contract holder residing in a non-nursing home portion of the continuing care retirement community, (d) a person who is an employee or a member of the board of trustees or board of directors of the continuing care retirement community, (e) a person who is a family member of an employee or a member of the board of trustees or board of directors of the continuing care retirement community, or (f) a person who is an accredited practitioner of the religious organization or denomination with which the continuing care retirement community is affiliated.

F. Any continuing care retirement community applicant for a certificate of public need to increase the number of nursing home beds shall authorize the State Corporation Commission to disclose such information to the Commissioner as may be in the State Corporation Commission's possession concerning such continuing care retirement community in order to allow the Commissioner to enforce the provisions of this section. The State Corporation Commission shall provide the Commissioner with the requested information when so authorized.

G. For the purposes of this section:

"Family member" means spouse, mother, father, son, daughter, brother, sister, aunt, uncle, or cousin by blood, marriage, or adoption.

"One-time, three-year open admission period" means the three years after the initial licensure of nursing home beds during which the continuing care retirement community may take admissions directly into its nursing home beds without the signing of a standard contract. The facility or a related facility on the same campus shall not be granted any open admissions period for any subsequent application or authorization for nursing home beds.

"Qualified resident assistance policy" means a procedure, consistently followed by a facility, pursuant to which the facility endeavors to avoid requiring a resident to leave the facility because of inability to pay regular charges and which complies with the requirements of the Internal Revenue Service for maintenance of status as a tax exempt charitable organization under § 501(c)(3) of the Internal Revenue Code. This policy shall be (i) generally made known to residents through the resident contract and (ii) supported by reasonable and consistent efforts to promote the availability of funds, either through a special fund, separate foundation or access to other available funds, to assist residents who are unable to pay regular charges in whole or in part.

This policy may (a) take into account the sound financial management of the facility, including existing reserves, and the reasonable requirements of lenders and (b) include requirements that residents seeking such assistance provide all requested financial information and abide by reasonable conditions, including seeking to qualify for other assistance and restrictions on the transfer of assets to third parties.

A qualified resident assistance policy shall not constitute the business of insurance as defined in Chapter 1 (§ 38.2-100 et seq.) of Title 38.2.

"Standard contract" means a contract requiring the same entrance fee, terms, and conditions as contracts executed with residents of the non-nursing home portion of the facility, if the entrance fee is no less than the amount defined in § 38.2-4900.

H. This section shall not be construed to prohibit or prevent a continuing care retirement community from discharging a resident (i) for breach of nonfinancial contract provisions, (ii) if medically appropriate care can no longer be provided to the resident, or (iii) if the resident is a danger to himself or others while in the facility.

I. The provisions of subsections D, E, and H shall not affect any certificate of public need issued prior to July 1, 1998; however, any certificate of public need application for additional nursing home beds shall be subject to the provisions of this act.

1989, c. 517; 1990, cc. 191, 478, 753, 845; 1991, c. 561; 1992, cc. 612, 682; 1993, cc. 347, 474, 540, 564, 704, 762, 957, 993; 1994, cc. 57, 680, 711, 726, 797; 1995, cc. 505, 632, 641, 695, 753; 1996, cc. 531, 849, 901; 1998, c. 794; 2009, c. 175; 2012, c. 492; 2013, cc. 433, 515.

§ 32.1-102.3:2.1. Repealed.
Repealed by Acts 1998, c. 794.

§ 32.1-102.3:2.2. Expired.
Expired.

§§ 32.1-102.3:3, 32.1-102.3:4. Repealed.
Repealed by Acts 1992, c. 612.

§§ 32.1-102.3:5, 32.1-102.3:6. Repealed.
Repealed by Acts 2012, c. 301, cl. 1.

§ 32.1-102.3:7. Application for transfer of nursing facility beds.
A. Notwithstanding the provisions of § 32.1-102.3:2, the Commissioner shall accept and may approve applications for the transfer of nursing facility beds from one planning district to another planning district when no Request for Applications has been issued in cases in which the applicant can demonstrate (i) there is a shortage of nursing facility beds in the planning district to which beds are proposed to be transferred, (ii) the number of nursing facility beds in the planning district from which beds are proposed to be moved exceeds the need for such beds, (iii) the proposed transfer of nursing facility beds would not result in creation of a need for additional beds in the planning district from which the

beds are proposed to be transferred, and (iv) the nursing facility beds proposed to be transferred will be made available to individuals in need of nursing facility services in the planning district to which they are proposed to be transferred without regard to the source of payment for such services.

B. Applications received pursuant to this section shall be subject to the provisions of this article governing review of applications for certificate of public need.

2013, c. 515.

§ 32.1-102.3:8. Application for an open admission period for a continuing care retirement community.

A. Notwithstanding the provisions of § 32.1-102.3:2, the Commissioner shall accept and may approve applications for a two-year or three-year open admission period for a continuing care retirement community nursing facility approved as part of an initial certificate of public need pursuant to subsection E of § 32.1-102.3:2.

B. Any person seeking an open admission period pursuant to subsection A shall provide written notice of the proposed open admission period to all nursing facilities located within the planning district. The Commissioner shall accept public comment on an application for an open admission period pursuant to subsection A for a period of 14 days following submission of the application.

2013, c. 515.

§ 32.1-102.4. Conditions of certificates; monitoring; revocation of certificates; civil penalties.

A. The Commissioner may, in accordance with regulations of the Board, condition issuance of a certificate on compliance with a schedule for the completion of the proposed project and a maximum capital expenditure amount for the proposed project. The approved schedule and maximum capital expenditure for a proposed project shall be issued together with the certificate. The approved schedule may not be extended and the maximum capital expenditure may not be exceeded without the approval of the Commissioner in accordance with the regulations of the Board. The Commissioner shall not approve an extension for a schedule for completion of any project or the exceeding of the maximum capital expenditure of any project unless such extension or excess complies with the limitations provided in the regulations promulgated by the Board pursuant to § 32.1-102.2.

The Commissioner shall monitor each project to determine its progress and compliance with the approved schedule and with the maximum capital expenditure, and may revoke the certificate for (i) lack of substantial and continuing progress toward completion of the project in accordance with the schedule or (ii) expenditures in excess of the approved maximum capital expenditure for the project.

Any person willfully violating conditions imposed pursuant to this subsection shall be subject to a civil penalty of up to $100 per violation per day until the date of completion of the project which shall be collected by the Commissioner and paid into the Literary Fund.

For the purposes of this subsection, "completion" means conclusion of construction activities necessary for the substantial performance of the contract.

B. The Commissioner shall, pursuant to the regulations of the Board, condition the approval of a certificate upon the agreement of the applicant to provide care to individuals who are eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), and 10 U.S.C. § 1071 et seq. In addition, the Commissioner shall condition the approval of a certificate upon the agreement of the applicant to (i) provide a specified level of charity care to indigent persons or accept patients requiring specialized care, (ii) facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area, or (iii) all of the above. Except in the case of nursing homes, the value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

Every certificate holder shall develop a financial assistance policy that includes specific eligibility criteria and procedures for applying for charity care, which shall be provided to a patient at the time of admission or discharge or at the time services are provided, included with any billing statements sent to uninsured patients, posted conspicuously in public areas of the medical care facility for which the certificate was issued and posted on a website maintained by the certificate holder.

The certificate holder shall annually provide documentation to the Department demonstrating that the certificate holder has satisfied the conditions of the certificate, including documentation of the amount of charity care provided to patients. If the certificate holder is unable or fails to satisfy the conditions of a certificate, the Department may approve alternative methods to satisfy the conditions pursuant to a plan of compliance, which shall identify a timeframe within which the certificate holder will satisfy the conditions of the certificate, and identify how the certificate holder will satisfy the conditions of the certificate, which may include (a) making direct payments to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, (b) making direct payments to a private nonprofit foundation that funds basic insurance coverage for indigents authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, or (c) other documented efforts or initiatives to provide primary or specialized care to underserved populations. In cases in which the certificate holder holds more than one certificate with conditions pursuant to this subsection, and the certificate holder is unable to satisfy the conditions of one certificate, such plan of compliance may provide for satisfaction of the conditions on that certificate by providing care at a reduced rate to indigent individuals in excess of the amount required by another certificate issued to the same holder, in an amount approved by the Department provided such care is offered at the same facility. Nothing in the preceding sentence shall prohibit the satisfaction of conditions of more than one certificate among various affiliated facilities or certificates subject to a system-wide or all-inclusive charity care condition established by the Commissioner. In determining whether the certificate holder has met the conditions of the certificate pursuant to a plan of compliance, only such actions undertaken after issuance of the conditioned certificate shall be counted towards satisfaction of conditions.

Any person refusing, failing, or neglecting to honor such agreement shall be subject to a civil penalty of up to $100 per violation per day until the date of compliance which shall be collected by the Commissioner and paid into the Literary Fund. For the purpose of determining the amount of a civil penalty imposed pursuant to this subsection, the date on which the person began providing services in accordance with the original certificate shall be the date from which the period of noncompliance shall be calculated.

C. The Commissioner shall (i) review every certificate of public need upon which conditions were imposed pursuant to subsection B at least once every three years to determine whether such conditions continue to be appropriate or should be revised and (ii) notify each certificate holder of his conclusions regarding (a) the appropriateness of conditions imposed on the certificate and whether such conditions should be revised and (b) the process by which the certificate holder may request amendments to conditions imposed on a certificate in accordance with subsection D.

D. Pursuant to regulations of the Board, the Commissioner may accept requests for and approve amendments to conditions of existing certificates related to the provision of care at reduced rates or to patients requiring specialized care or related to the development and operation of primary medical care services in designated medically underserved areas of the certificate holder's service area.

E. In determining whether conditions imposed on a certificate of public need pursuant to subsection B are appropriate for the purposes of subsection C or should be amended in response to a request submitted pursuant to subsection D, the Commissioner shall consider any changes in the circumstances of the certificate holder resulting from changes in the financing or delivery of health care services, including changes to the Commonwealth's program of medical assistance services, and any other specific circumstances of the certificate holder.

1982, c. 388; 1991, c. 561; 1992, c. 682; 1993, cc. 668, 704; 1998, c. 794; 2009, cc. 175, 711, 796, 877; 2013, c. 460; 2017, cc. 768, 791; 2019, c. 839; 2020, c. 1271.

§ 32.1-102.5. Certificate not transferable.

No certificate issued for a project shall be transferable.

1982, c. 388.

§ 32.1-102.6. Administrative procedures.

A. To obtain a certificate for a project, the applicant shall file a completed application for a certificate with the Department and the appropriate regional health planning agency if a regional health planning agency has been designated for that region. Such application shall be filed in accordance with procedures established by the Department. An application submitted for review shall be considered complete when all relevant sections of the application form have responses. The applicant shall provide sufficient information to prove public need for the requested project exists without the addition of supplemental or supporting material at a later date. The Department shall ensure that only data necessary for review of an application is required to be submitted and that the application reflects statutory

requirements. Nothing in this section shall prevent the Department from seeking, at its discretion, additional information from the applicant or other sources.

Within 10 calendar days of the date on which the document is received, the Department and the appropriate regional health planning agency, if a regional health planning agency has been designated, shall determine whether the application is complete or not and the Department shall notify the applicant, if the application is not complete, of the information needed to complete the application. If no regional health planning agency is designated for the health planning region in which the project will be located, no filing with a regional health planning agency is required and the Department shall determine if the application is complete and notify the applicant, if the application is not complete, of the information needed to complete the application.

At least 30 calendar days before any person is contractually obligated to acquire an existing medical care facility, the cost of which is $600,000 or more, that person shall notify the Commissioner and the appropriate regional health planning agency, if a regional health planning agency has been designated, of the intent, the services to be offered in the facility, the bed capacity in the facility and the projected impact that the cost of the acquisition will have upon the charges for services to be provided. If clinical services or beds are proposed to be added as a result of the acquisition, the Commissioner may require the proposed new owner to obtain a certificate prior to the acquisition. If no regional health planning agency is designated for the health planning region in which the acquisition will take place, no notification to a regional health planning agency shall be required.

B. For projects proposed in health planning regions with regional planning agencies, the appropriate regional health planning agency shall (i) review each completed application for a certificate within 60 calendar days of the day that begins the appropriate batch review cycle as established by the Board by regulation pursuant to subdivision A 1 of § 32.1-102.2, such cycle not to exceed 190 days in duration; (ii) within 10 calendar days following the start of the review cycle, solicit public comment on such application by posting notice of such application and a summary of the proposed project on a website maintained by the Department; such notice shall include information about how comments may be submitted to the regional health planning agency and the date on which the public comment period shall expire, which shall be no later than 45 calendar days following the date of the public notice; and (iii) in the case of competing applications or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public, hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. Prior to any required public hearing, the regional health planning agency shall notify the local governing bodies in the planning district. At least nine days prior to the public hearing, the regional health planning agency shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where the project is proposed to be located. The regional health planning agency shall consider the comments of the local governing bodies in the planning district and all other public comments in making its decision. Such comments shall be part of the record. In no case shall a regional health planning

agency hold more than two meetings on any application, one of which shall be the public hearing required pursuant to clause (iii), if any, conducted by the board of the regional health planning agency or a subcommittee of the board. The applicant shall be given the opportunity, prior to the vote by the board of the regional health planning agency or a committee of the agency, if acting for the board, on its recommendation, to respond to any comments made about the project by the regional health planning agency staff, any information in a regional health planning agency staff report, or comments by those voting members of the regional health planning agency board; however, such opportunity shall not increase the 60-calendar-day period designated herein for the regional health planning agency's review unless the applicant or applicants request a specific extension of the regional health planning agency's review period.

The regional health planning agency shall submit its recommendations on each application and its reasons therefor to the Department within 10 calendar days after the completion of its 60-calendar-day review or such other period in accordance with the applicant's request for extension.

If the regional health planning agency has not completed its review within the specified 60 calendar days or such other period in accordance with the applicant's request for extension and submitted its recommendations on the application and the reasons therefor within 10 calendar days after the completion of its review, the Department shall, on the eleventh calendar day after the expiration of the regional health planning agency's review period, proceed as though the regional health planning agency has recommended project approval without conditions or revision.

If no regional health planning agency has been designated for a region, the Department shall (a) within 10 calendar days following the start of the review cycle, solicit public comment on such application by posting notice of such application and a summary of the proposed project on a website maintained by the Department; such notice shall include such information about how comments may be submitted to the Department and the date on which the public comment period shall expire, which shall be no later than 45 calendar days following the date of the public notice, and (b) in the case of competing applications or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public, hold one hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. Prior to any required hearing, the Department shall notify the local governing bodies in the planning district in which the project is proposed. At least nine days prior to the public hearing, the Department shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where the project is proposed to be located. The Department shall consider the comments of the local governing bodies in the planning district and all other public comments in making its decision. Such comments shall be part of the record.

C. After commencement of any public hearing and before a decision is made there shall be no ex parte contacts concerning the subject certificate or its application between (i) any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need and (ii) any person in the Department who has authority to

make a determination respecting the issuance or revocation of a certificate of public need, unless the Department has provided advance notice to all parties referred to in clause (i) of the time and place of such proposed contact.

D. The Department shall commence the review of each completed application upon the day which begins the appropriate batch review cycle and simultaneously with the review conducted by the regional health planning agency, if a regional health planning agency has been designated.

A determination whether a public need exists for a project shall be made by the Commissioner within 190 calendar days of the day which begins the appropriate batch cycle.

The 190-calendar-day review period shall begin on the date upon which the application is determined to be complete within the batching process specified in subdivision A 1 of § 32.1-102.2.

If the application is not determined to be complete within 40 calendar days from submission, the application shall be refiled in the next batch for like projects.

The Commissioner shall make determinations in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.) except for those parts of the determination process for which timelines and specifications are delineated in subsection E. Further, if an informal fact-finding conference is determined to be necessary by the Department or is requested by a person seeking good cause standing, the parties to the case shall include only the applicant, any person showing good cause, any third-party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, and the relevant health planning agency.

E. Upon entry of each completed application or applications into the appropriate batch review cycle:

1. The Department shall establish, for every application, a date between the eightieth and ninetieth calendar days within the 190-calendar-day review period for holding an informal fact-finding conference, if such conference is necessary.

2. The Department shall review every application at or before the seventy-fifth calendar day within the 190-calendar-day review period to determine whether an informal fact-finding conference is necessary.

3. Any person seeking to be made a party to the case for good cause, no later than four days after the Department has completed its review and submitted its recommendation on an application and has transmitted the same to the applicants and to persons who have, prior to the issuance of the report, requested a copy in writing, shall notify the Commissioner, all applicants, and the regional health planning agency, in writing and under oath, stating the grounds for good cause and providing the factual basis therefor.

4. In any case in which an informal fact-finding conference is held, a date shall be established for the closing of the record which shall not be more than 30 calendar days after the date for holding the informal fact-finding conference.

5. In any case in which an informal fact-finding conference is not held, the record shall be closed on the earlier of (i) the date established for holding the informal fact-finding conference or (ii) the date that the Department determines an informal fact-finding conference is not necessary.

6. The provisions of subsection C of § 2.2-4021 notwithstanding, if a determination whether a public need exists for a project is not made by the Commissioner within 45 calendar days of the closing of the record, the Commissioner shall notify the applicant or applicants and any persons seeking to show good cause, in writing, that the application or the application of each shall be deemed approved 25 calendar days after expiration of such 45-calendar-day period, unless the receipt of recommendations from the person performing the hearing officer functions permits the Commissioner to issue his case decision within that 25-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise impact the effectiveness of this section.

7. In any case when a determination whether a public need exists for a project is not made by the Commissioner within 70 calendar days after the closing of the record, the application shall be deemed to be approved and the certificate shall be granted.

8. If a determination whether a public need exists for a project is not made by the Commissioner within 45 calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications issued pursuant to § 32.1-102.3:2 may, prior to the application being deemed approved, petition for immediate injunctive relief pursuant to § 2.2-4030, naming as respondents the Commissioner and all parties to the case. During the pendency of the proceeding, no applications shall be deemed to be approved. In such a proceeding, the provisions of § 2.2-4030 shall apply.

F. Deemed approvals shall be construed as the Commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) and shall be subject to judicial review on appeal as the Commissioner's case decision in accordance with such act.

Any person who has sought to participate in the Department's review of such deemed-to-be-approved application as a person showing good cause who has not received a final determination from the Commissioner concerning such attempt to show good cause shall be deemed to be a person showing good cause for purposes of appeal of the deemed approval of the certificate.

In any appeal of the Commissioner's case decision granting a certificate of public need pursuant to a Request for Applications issued pursuant to § 32.1-102.3:2, the court may require the appellant to file a bond pursuant to § 8.01-676.1, in such sum as shall be fixed by the court for protection of all parties interested in the case decision, conditioned on the payment of all damages and costs incurred in consequence of such appeal.

G. For purposes of this section, "good cause" means that (i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hear-

ing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health planning agency.

H. The project review procedures shall provide for separation of the project review manager functions from the hearing officer functions. No person serving in the role of project review manager shall serve as a hearing officer.

I. The applicants, and only the applicants, shall have the authority to extend any of the time periods specified in this section. If all applicants consent to extending any time period in this section, the Commissioner, with the concurrence of the applicants, shall establish a new schedule for the remaining time periods.

J. This section shall not apply to applications for certificates for projects defined in subdivision A 8 of § 32.1-102.1:3. Such projects shall be subject to an expedited application and review process developed by the Board in regulation pursuant to subdivision A 2 of § 32.1-102.2.

1982, c. 388; 1984, c. 740; 1991, c. 561; 1999, cc. 899, 922; 2000, c. 931; 2004, cc. 71, 95; 2005, c. 404; 2009, c. 175; 2010, c. 646; 2020, c. 1271.

§ 32.1-102.6:1. Revocation of a certificate.

The Commissioner shall revoke a certificate of public need for:

1. Failure to comply with the requirements of subsection A of § 32.1-102.4 regarding schedules for completion of a project or maximum capital expenditures for a project; or

2. Willfully or recklessly misrepresented intentions or facts in obtaining a certificate.

2020, c. 1271.

§ 32.1-102.7. Repealed.

Repealed by Acts 1984, c. 740.

§ 32.1-102.8. Enjoining project undertaken without certificate or registration.

On petition of the Commissioner, the Board or the Attorney General, the circuit court of the county or city where a project is under construction or is intended to be constructed, located, or undertaken shall have jurisdiction to enjoin any project that is constructed, undertaken, or commenced without a certificate or registration required by this article or to enjoin the admission of patients to the project or to enjoin the provision of services through the project.

1982, c. 388; 2020, c. 1271.

§ 32.1-102.9. Designation of judge.

The judge of the court to which any appeal is taken as provided in § 32.1-102.6 and the judge of the court referred to in § 32.1-102.8 shall be designated by the Chief Justice of the Supreme Court from a circuit other than the circuit where the project is or will be under construction, located or undertaken.

1982, c. 388; 1984, c. 740.

§ 32.1-102.10. Commencing project without certificate or registration grounds for refusing to issue license.

Commencing any project without a certificate or registration required by this article shall constitute grounds for refusing to issue a license for such project. Persons commencing any project without a certificate or registration as required by this article shall be subject to the penalties set forth in §§ 32.1-27 and 32.1-27.1.

1982, c. 388; 2009, c. 175; 2020, c. 1271.

§ 32.1-102.11. Application of article.

A. Every project of an existing or proposed medical care facility described in subsection A of § 32.1-102.1:3 shall be subject to all provisions of this article unless, with respect to such project, the owner or operator of an existing medical care facility or the developer of a proposed medical care facility (i) has, by February 1, 1992, purchased or leased equipment subject to registration pursuant to former § 32.1-102.3:4, (ii) has, by February 1, 1992, initiated construction requiring a capital expenditure exceeding one million dollars, or (iii) has made or contracted to make or otherwise legally obligated to make, during the three years ending February 1, 1992, preliminary expenditures of $350,000 or more for a formal plan of construction of the specific project, including expenditures for site acquisition, designs, preliminary or working drawings, construction documents, or other items essential to the construction of the specific project.

Any project exempted pursuant to subdivisions (ii) and (iii) of this subsection shall be limited to such construction, services, and equipment as specifically identified in the formal plan of construction which shall have existed and been formally committed to by February 1, 1992. Further, the equipment to be exempted pursuant to subdivisions (ii) and (iii) shall be limited to the number of units and any types of medical equipment, in the case of medical equipment intended to provide any services included in subdivision B 6 of § 32.1-102.1:3, as are specifically identified in such plan and, in the case of all other equipment, such equipment as is appropriate for the construction and services included in such plan.

None of the exemptions provided in this subsection shall be applicable to projects which required a certificate of public need pursuant to this article on January 1, 1992.

B. Any medical care facility or entity claiming to meet one of the conditions set forth in subsection A of this section shall file a completed application for an exemption from the provisions of this article with the Commissioner by August 1, 1992. Forms for such application shall be made available by the Commissioner no later than April 1, 1992. The Commissioner may deny an exemption if the application is not complete on August 1, 1992, and the medical care facility or entity has not filed a completed application within forty-five days after notice of deficiency in the filing of the completed application. After receiving a completed application, the Commissioner shall determine whether the project has met one of the criteria for an exemption and is, therefore, exempt or has not met any of the criteria for an exemption and is, therefore, subject to all provisions of this article and shall notify the medical care facility or entity of his determination within sixty days of the date of filing of the completed application. If it is

determined that an exemption exists for only a portion of a project, the Commissioner may approve an exemption for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. The Commissioner's determination shall be made in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.), except that parties to the case shall include only those parties specified in § 32.1-102.6.

C. For the purposes of this section:

"Formal plan of construction" means documentary evidence indicating that the facility, the owner or operator of the facility, or the developer of a proposed facility was formally committed to the project by February 1, 1992, and describing the specific project in sufficient detail to reasonably define and confirm the scope of the project including estimated cost, intended location, any clinical health services to be involved and any types of equipment to be purchased. Such documentary evidence shall include designs, preliminary or working drawings, construction documents or other documents which have been used to explicitly define and confirm the scope of the project for the purposes of seeking architectural or construction plans or capital to the extent that such capital was committed or agreed to be provided for such project prior to February 1, 1992.

"Initiated construction" means an owner or operator of an existing facility or the developer of a proposed facility can present evidence for a specific project that (i) a construction contract has been executed; (ii) if applicable, short-term financing has been completed; (iii) if applicable, a commitment for long-term financing has been obtained; and (iv) if the project is for construction of a new facility or expansion of an existing facility, predevelopment site work and building foundations have been completed.

"Leased" means that the owner or operator of an existing medical care facility or the developer of a proposed facility has a legally binding commitment to lease the equipment pursuant to an agreement providing for fixed, periodic payments commencing no later than June 30, 1992, including a lease-purchase agreement in which the owner or operator of the facility or developer has an option to purchase the equipment for less than fair market value upon conclusion of the lease or an installment sale agreement with fixed periodic payments commencing no later than June 30, 1992.

"Purchased" means that the equipment has been acquired by the owner or operator of an existing medical care facility or the developer of a proposed medical care facility, or the owner or operator of the facility or the developer can present evidence of a legal obligation to acquire the equipment in the form of an executed contract or appropriately signed order or requisition and payment has been made in full by June 30, 1992.

1982, c. 388; 1986, c. 615; 1992, c. 612; 2020, c. 1271.

§ 32.1-102.12. Repealed.

Repealed by Acts 2012, c. 123, cl. 1.

§ 32.1-102.13. Repealed.

Repealed by Acts 2007, c. 5, cl. 1.

Article 2 - MEDICAL CARE FACILITIES DEVELOPMENT

§§ 32.1-103 through 32.1-111. Repealed.

Repealed by Acts 1984, c. 424.

Article 2.1 - STATEWIDE EMERGENCY MEDICAL SERVICES SYSTEM AND SERVICES

§ 32.1-111.1. Definitions.

As used in this article:

"Advisory Board" means the State Emergency Medical Services Advisory Board.

"Automated external defibrillator" means a medical device which combines a heart monitor and defibrillator and (i) has been approved by the United States Food and Drug Administration, (ii) is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia, (iii) is capable of determining, without intervention by an operator, whether defibrillation should be performed, and (iv) automatically charges and requests delivery of an electrical impulse to an individual's heart, upon determining that defibrillation should be performed.

"Emergency medical services" or "EMS" means health care, public health, and public safety services used in the medical response to the real or perceived need for immediate medical assessment, care, or transportation and preventive care or transportation in order to prevent loss of life or aggravation of physiological or psychological illness or injury.

"Emergency medical services agency" or "EMS agency" means any person engaged in the business, service, or regular activity, whether for profit or not, of rendering immediate medical care and providing transportation to persons who are sick, injured, wounded, or otherwise incapacitated or helpless and that holds a valid license as an emergency medical services agency issued by the Commissioner in accordance with § 32.1-111.6.

"Emergency medical services personnel" or "EMS personnel" means individuals who are employed by or members of an emergency medical services agency and who provide emergency medical services pursuant to an emergency medical services agency license issued to that agency by the Commissioner and in accordance with the authorization of that agency's operational medical director.

"Emergency medical services physician" or "EMS physician" means a physician who holds a current endorsement from the Office of Emergency Medical Services (EMS) and may serve as an EMS agency operational medical director or training program physician course director.

"Emergency medical services provider" or "EMS provider" means any person who holds a valid certificate as an emergency medical services provider issued by the Commissioner.

"Emergency medical services system" or "EMS system" means the system of emergency medical services agencies, vehicles, equipment, and personnel; health care facilities; other health care and emergency services providers; and other components engaged in the planning, coordination, and delivery

of emergency medical services in the Commonwealth, including individuals and facilities providing communication and other services necessary to facilitate the delivery of emergency medical services in the Commonwealth.

"Emergency medical services vehicle" means any vehicle, vessel, or aircraft that holds a valid emergency medical services vehicle permit issued by the Office of Emergency Medical Services that is equipped, maintained, or operated to provide emergency medical care or transportation of patients who are sick, injured, wounded, or otherwise incapacitated or helpless.

"Office of Emergency Medical Services" means the Office of Emergency Medical Services of the Department.

"Operational medical director" or "OMD" means an EMS physician, currently licensed to practice medicine or osteopathic medicine in the Commonwealth, who is formally recognized and responsible for providing medical direction, oversight, and quality improvement to an EMS agency.

1996, c. 899; 1999, c. 1000; 2000, c. 939; 2008, c. 118; 2015, cc. 502, 503.

§ 32.1-111.2. Exemptions from provisions of this article.

The following entities are exempted from the provisions of this article:

1. Emergency medical services agencies based outside the Commonwealth, except that any such agency receiving a person who is sick, injured, wounded, incapacitated, or helpless within the Commonwealth for transportation to a location within the Commonwealth shall comply with the provisions of this article;

2. Emergency medical services agencies operated by the United States government; and

3. Wheelchair interfacility transport services and wheelchair interfacility transport service vehicles that are engaged, whether or not for profit, in the business, service, or regular activity of and exclusively used for transporting wheelchair bound passengers between medical facilities in the Commonwealth when no ancillary medical care or oversight is necessary. However, such services and vehicles shall comply with Department of Medical Assistance Services regulations regarding the transportation of Medicaid recipients to covered services.

1996, c. 899; 2005, c. 778; 2015, cc. 502, 503.

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

tronic 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. 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.

1996, c. 899; 1997, c. 321; 1998, c. 317; 1999, c. 1000; 2005, cc. 632, 686; 2006, c. 412; 2007, c. 15; 2008, cc. 66, 567; 2009, cc. 222, 269; 2012, c. 418; 2014, c. 320; 2015, cc. 502, 503; 2017, c. 609; 2018, cc. 103, 109.

§ 32.1-111.4. Regulations; emergency medical services personnel and vehicles; response times; enforcement provisions; civil penalties.

A. The Board shall prescribe by regulation:

1. Requirements for recordkeeping, supplies, operating procedures, and other emergency medical services agency operations;

2. Requirements for the sanitation and maintenance of emergency medical services vehicles and their medical supplies and equipment;

3. Procedures, including the requirements for forms, to authorize qualified emergency medical services personnel to follow Do Not Resuscitate Orders pursuant to § 54.1-2987.1;

4. Requirements for the composition, administration, duties, and responsibilities of the Advisory Board;

5. Requirements, developed in consultation with the Advisory Board, governing the training, certification, and recertification of emergency medical services personnel;

6. Requirements for written notification to the Advisory Board, the Office of Emergency Medical Services, and the Financial Assistance and Review Committee of the Board's action, and the reasons therefor, on requests and recommendations of the Advisory Board, the Office of Emergency Medical Services, or the Financial Assistance and Review Committee, no later than five business days after reaching its decision, specifying whether the Board has approved, denied, or not acted on such requests and recommendations;

7. Authorization procedures, developed in consultation with the Advisory Board, that allow the possession and administration of epinephrine or a medically accepted equivalent for emergency cases of anaphylactic shock by certain levels of certified emergency medical services personnel as authorized by § 54.1-3408 and authorization procedures that allow the possession and administration of oxygen with the authority of the local operational medical director and an emergency medical services agency that holds a valid license issued by the Commissioner;

8. A uniform definition of "response time" and requirements, developed in consultation with the Advisory Board, for each emergency medical services agency to measure response times starting from the time a call for emergency medical services is received until the time (i) appropriate emergency medical services personnel are responding and (ii) appropriate emergency medical services personnel

arrive on the scene, and requirements for emergency medical services agencies to collect and report such data to the Director of the Office of Emergency Medical Services, who shall compile such information and make it available to the public, upon request;

9. Enforcement provisions, including, but not limited to, civil penalties that the Commissioner may assess against any emergency medical services agency or other entity found to be in violation of any of the provisions of this article or any regulation promulgated under this article. All amounts paid as civil penalties for violations of this article or regulations promulgated pursuant thereto shall be paid into the state treasury and shall be deposited in the emergency medical services special fund established pursuant to § 46.2-694, to be used only for emergency medical services purposes; and

10. Procedures for when emergency medical services agencies in medically underserved areas as defined by the Board may transport patients to 24-hour urgent care facilities or appropriate medical care facilities other than hospitals. The regulations shall include provisions for what constitutes a medically underserved area, cases appropriate for transferring a patient to a medical facility other than a hospital, and other information deemed relevant by the Board.

B. The Board shall classify emergency medical services agencies and emergency medical services vehicles by type of service rendered and shall specify the medical equipment, the supplies, the vehicle specifications, and the emergency medical services personnel required for each classification.

C. In formulating its regulations, the Board shall consider the current Minimal Equipment List for Ambulances adopted by the Committee on Trauma of the American College of Surgeons.

1996, c. 899; 1997, c. 248; 1998, cc. 803, 854; 2001, c. 466; 2003, c. 1020; 2005, c. 921; 2006, c. 194; 2015, cc. 502, 503; 2020, c. 930.

§ 32.1-111.4:1. State Emergency Medical Services Advisory Board; purpose; membership; duties; reimbursement of expenses; staff support.

A. There is hereby created in the executive branch the State Emergency Medical Services Advisory Board for the purpose of advising the Board concerning the administration of the statewide emergency medical services system and emergency medical services vehicles maintained and operated to provide transportation to persons requiring emergency medical treatment and for reviewing and making recommendations on the Statewide Emergency Medical Services Plan. The Advisory Board shall be composed of 28 members appointed by the Governor as follows: one representative each from the Virginia Municipal League, Virginia Association of Counties, Virginia Hospital and Healthcare Association, and each of the 11 regional emergency medical services councils; one member each from the Medical Society of Virginia, Virginia Chapter of the American College of Emergency Physicians, Virginia Chapter of the American College of Surgeons, Virginia Chapter of the American Academy of Pediatrics, Emergency Nurses Association or the Virginia Nurses' Association, Virginia State Firefighters Association, Virginia Fire Chiefs Association, Virginia Ambulance Association, Virginia Association of Governmental Emergency Medical Services Administrators, and Virginia Association of Public Safety Communications Officials; two representatives of the Virginia Association of Volunteer

Rescue Squads, Inc.; one Virginia professional firefighter; and one consumer who shall not be involved in or affiliated with emergency medical services in any capacity. Each organization and group shall submit three nominees from among which the Governor may make appointments. Of the three nominees submitted by each of the regional emergency medical services councils, at least one nominee shall be a representative of providers of prehospital care. Any person appointed to the Advisory Board shall be a member of the organization that he represents. To ensure diversity in the organizations and groups represented on the Advisory Board, the Governor may request additional nominees from the applicable organizations and groups. However, the Governor shall not be bound to make any appointment from among any nominees recommended by such organizations and groups.

The members of the Advisory Board shall not be eligible to receive compensation; however, the Department shall provide funding for the reimbursement of expenses incurred by members of the Advisory Board in the performance of their duties.

B. Appointments shall be staggered as follows: nine members for a term of two years, nine members for a term of three years, and 10 members for a term of four years. Thereafter, appointments shall be for terms of three years, except an appointment to fill a vacancy, which shall be for the unexpired term. Appointments shall be in a manner to preserve insofar as possible the representation of the specified groups. No member shall serve more than two successive terms. No person representing any organization or group named in subsection A who has served as a member of the Advisory Board for two or more successive terms for any period or for six or more consecutive years shall be nominated for appointment or appointed to the Advisory Board unless at least three consecutive years have elapsed since the person has served on the Advisory Board.

The chairman shall be elected from the membership of the Advisory Board for a term of one year and shall be eligible for reelection. The Advisory Board shall meet at least four times annually at the call of the chairman or the Commissioner.

C. The Advisory Board shall:

1. Advise the Board on the administration of this article;

2. Review and make recommendations for the Statewide Emergency Medical Services Plan and any revisions thereto; and

3. Review, on a schedule as it may determine, reports on the status of all aspects of the statewide emergency medical services system, including the Financial Assistance and Review Committee, the Rescue Squad Assistance Fund, the regional emergency medical services councils, and the emergency medical services vehicles, submitted by the Office of Emergency Medical Services.

D. The Advisory Board shall establish an Advisory Board Executive Committee to assist in the work of the Advisory Board. The Advisory Board Executive Committee shall, in addition to those duties of the Advisory Board Executive Committee established by the Advisory Board, review the annual financial report of the Virginia Association of Volunteer Rescue Squads, as required by § 32.1-111.13.

E. The Office of Emergency Medical Services shall provide staff support to the Advisory Board.

2015, cc. 502, 503.

§ 32.1-111.4:2. Regional emergency medical services councils.

The Board shall designate regional emergency medical services councils that shall be authorized to receive and disburse public funds. Each such council shall be charged with the development and implementation of an efficient and effective regional emergency medical services delivery system.

The Board shall review those agencies that were the designated regional emergency medical services councils. The Board shall, in accordance with the standards established in its regulations, review and may renew or deny applications for such designations every three years. In its discretion, the Board may establish conditions for renewal of such designations or may solicit applications for designation as a regional emergency medical services council.

Each regional emergency medical services council shall include, if available, representatives of the participating local governments, fire protection agencies, law-enforcement agencies, emergency medical services agencies, hospitals, licensed practicing physicians, emergency care nurses, mental health professionals, emergency medical services personnel, and other appropriate allied health professionals.

Each regional emergency medical services council shall adopt and revise as necessary a regional emergency medical services plan in cooperation with the Board.

The designated regional emergency services councils shall be required to match state funds with local funds obtained from private or public sources in the proportion specified in the regulations of the Board. Moneys received directly or indirectly from the Commonwealth shall not be used as matching funds. A local governing body may choose to appropriate funds for the purpose of providing matching grant funds for any designated regional emergency medical services council. However, this section shall not be construed to place any obligation on any local governing body to appropriate funds to any such council.

The Board shall promulgate, in cooperation with the Advisory Board, regulations to implement this section, which shall include, but not be limited to, requirements to ensure accountability for public funds, criteria for matching funds, and performance standards.

2015, cc. 502, 503.

§ 32.1-111.4:3. Provision of emergency medical services.

A. Any county, city, or town may provide emergency medical services to its citizens by (i) establishing an emergency medical services agency as a department of government pursuant to § 32.1-111.4:6 or (ii) contracting with or providing for the provision of emergency medical services by an emergency medical services agency established pursuant to § 32.1-111.4:7.

B. In cases in which a county, city, or town elects to contract with or provide for emergency medical services by an emergency medical services agency pursuant to clause (ii) of subsection A, the

emergency medical services agency shall be deemed to be an instrumentality of the county, city, or town and, as such, exempt from suit for damages done incident to the provision of emergency medical services therein unless the emergency medical services agency is a private, for-profit emergency medical services agency.

2015, cc. 502, 503.

§ 32.1-111.4:4. Emergency medical services personnel and equipment may in emergencies go or be sent beyond territorial limits.

Whenever the necessity arises during any actual or potential emergency resulting from fire, personal injury, or other public disaster, the emergency medical services personnel of any county, city, or town may, together with all necessary equipment, lawfully go or be sent beyond the territorial limits of such county, city, or town to any point within or without the Commonwealth to assist in meeting such emergency.

In such event, the acts performed by such fire or emergency medical services personnel and the expenditures made for such purpose by such county, city, or town shall be deemed conclusively to be for a public and governmental purpose, and all of the immunities from liability enjoyed by a county, city, or town when acting through its emergency medical services personnel for a public or governmental purpose within its territorial limits shall be enjoyed by it to the same extent when such county, city, or town is so acting, under this section or under other lawful authority, beyond its territorial limits.

Emergency medical services personnel of any county, city, or town, when acting hereunder or under other lawful authority beyond the territorial limits of such county, city, or town, shall have all the immunities from liability and exemptions from laws, ordinances, and regulations and shall have all of the pension, relief, disability, workers' compensation, and other benefits enjoyed by them while performing their respective duties.

2015, cc. 502, 503.

§ 32.1-111.4:5. Contracts of counties, cities, and towns to furnish emergency medical services; public liability insurance to cover claims arising out of mutual aid agreements.

A. The governing body of any city or town may, in its discretion, authorize or require the emergency medical services agency thereof to render aid in cases of actual or potential medical emergencies occurring beyond its limits, may prescribe the conditions under which such aid may be rendered, and may enter into contracts with nearby, adjacent, or adjoining counties and cities, within or without the Commonwealth, including the District of Columbia, for rendering aid in the provision of emergency medical services in such counties, cities, or any district, or sanitary district thereof or in the District of Columbia, on such terms as may be agreed upon by such governing body and the governing body of the District of Columbia or of such counties and cities, or districts, including sanitary districts, provided that each of the parties to such agreement may contract as follows: (i) waive any and all claims against all the other parties thereto that may arise out of their activities outside their respective

jurisdictions under such agreement; (ii) indemnify and save harmless the other parties to such agreement from all claims by third parties for property damage or personal injury that may arise out of the activities of the other parties to such agreement outside their respective jurisdictions under such agreement. When the emergency medical services agency of any city or town is operating under such permission or contracts on any call beyond the corporate limits of the city or town, it shall be deemed to be operating in a governmental capacity, and subject only to such liability for injuries as it would be if it were operating within the corporate limits of such city or town.

B. Any county, city, or town may contract with the federal or state government to provide emergency medical services to federal or state property located within or without the boundaries of the county, city, or town. In the absence of a written contract, any acts performed and all expenditures made by a county, city, or town in providing emergency medical services to property owned by the federal government shall be deemed conclusively to be for a public and governmental purpose, and all of the immunities from liability enjoyed by a county, city, or town when acting through its emergency medical services personnel for a public or governmental purpose within or without its territorial limits shall be enjoyed by it to the same extent when such county, city, or town is so acting, under the provisions of this section or under other lawful authority.

Emergency medical services personnel of any county, city, or town when acting hereunder, or under other lawful authority, shall have all of the immunities from liability and exemptions from laws, ordinances, and regulations and shall have all of the pension, relief, disability, workers' compensation, and other benefits enjoyed by them while performing their respective duties. The amount of compensation to the county, city, or town pursuant to the contract shall be a matter within the sole discretion of the governing body of the county, city, or town.

C. The governing body of any county adjoining or near any county, city, or town, within or without the Commonwealth, including the District of Columbia, having and maintaining emergency medical services equipment may contract with any such county, city, or town, upon such terms as such governing body may deem proper, for responding to medical emergencies in such county, city, or town and may prescribe the terms and conditions upon which such services may be provided on privately owned property in the county, city, or town and may raise funds with which to pay for such services, by levying and collecting annually, at such rates as such governing body may deem sufficient, a special tax upon the property in such county, or in any magisterial district thereof, subject to local taxation.

D. The governing body of any county, city, or town in the Commonwealth is authorized to procure or extend the necessary public liability insurance to cover claims arising out of mutual aid agreements executed with other counties, cities, or towns outside the Commonwealth, including the District of Columbia.

2015, cc. 502, 503.

§ 32.1-111.4:6. Establishment of an emergency medical services agency as a department of local government.

A. The governing body of any county, city, or town may establish an emergency medical services agency as a department of government and may designate it by any name consistent with the names of its other governmental units. The head of such emergency medical services agency shall be known as "the emergency medical services agency chief" or "EMS chief." As many other officers and employees may be employed in such emergency medical services agency as the governing body may approve.

B. An emergency medical services agency established pursuant to subsection A may consist of government-employed emergency medical services personnel, volunteer emergency medical services personnel, or both. If an emergency medical services agency established pursuant to this section includes volunteer emergency medical services personnel, such volunteer emergency medical services agency shall be deemed an instrumentality of the county, city, or town and, as such, exempt from suit for damages done incident to providing emergency medical services to the county, city, or town.

C. The governing body of any county, city, or town may empower an emergency medical services agency established therein pursuant to this section to make bylaws to promote its objects consistent with the laws of the Commonwealth and ordinances of the county, city, or town and may provide for the compensation of the officers and employees of such agency.

D. All check stubs or time cards purporting to be a record of time spent on the job by emergency medical services personnel employed by an emergency medical services agency established pursuant to this section shall record all hours of employment, regardless of how spent. All check stubs or pay records purporting to show the hourly compensation of emergency medical services personnel employed by an emergency medical services agency established pursuant to this section shall show the actual hourly wage to be paid. Nothing in this section shall require the showing of such information on check stubs, time cards, or pay records; however, if such information is shown, the information shall be in compliance with this section.

2015, cc. 502, 503.

§ 32.1-111.4:7. Establishment of an emergency medical services agency as a nongovernmental entity; dissolution.

A. Any number of persons wishing to provide emergency medical services may establish an emergency medical services agency by (i) recording a writing stating the formation of such company, with the names of the members thereof thereto subscribed in the court of the county or city wherein such agency shall be located, (ii) complying with such local ordinances as may exist related to establishment of an emergency medical services agency, and (iii) obtaining a valid emergency medical services agency license from the Office of Emergency Medical Services together with such emergency medical services vehicle permits from the Office of Emergency Medical Services as the Office of Emergency Medical Services may require. The principal officer of such emergency medical services agency shall be known as "the emergency medical services agency chief" or "EMS chief."

B. The members of an emergency medical services agency established pursuant to subsection A may make regulations for effecting its objects consistent with the laws of the Commonwealth; the ordinances of the county, city, or town; and the bylaws of the emergency medical services agency thereof.

C. In every county, city, or town in which an emergency medical services agency is established pursuant to this section, there shall be appointed, at such time and in such manner as the governing body of such county, city, or town in which the emergency medical services agency is located may prescribe, an emergency medical services agency chief and as many other officers of the emergency medical services agency as such governing body may direct.

D. An emergency medical services agency established pursuant to this section may be dissolved when the local governing body of the county, city, or town in which the emergency medical services agency is located determines that the emergency medical services agency has failed, for three months successively, to have or keep in good and serviceable condition emergency medical services vehicles and equipment and other proper implements, or when the governing body of the county, city, or town for any reason deems it advisable.

E. Upon dissolution of an emergency medical services agency established pursuant to this section, any property that was in the possession of such emergency medical services agency and that was purchased using public funds shall be offered to a city or county served by the emergency medical services agency to be used for the public good.

2015, cc. 502, 503; 2020, c. 946.

§ 32.1-111.4:8. Ordinances as to emergency medical services agencies.

The governing body of any county, city, or town in which an emergency medical services agency is established pursuant to § 32.1-111.4:6 or 32.1-111.4:7 may make such ordinances in relation to the powers and duties of emergency medical services agencies and emergency medical services agency chiefs or other officers of such emergency medical services agencies as it may deem proper.

2015, cc. 502, 503.

§ 32.1-111.5. Certification and recertification of emergency medical services providers; appeals process.

A. The Board shall prescribe by regulation the qualifications required for certification of emergency medical services providers, including those qualifications necessary for authorization to follow Do Not Resuscitate Orders pursuant to § 54.1-2987.1. Such regulations shall include criteria for determining whether an applicant's relevant practical experience and didactic and clinical components of education and training completed during his service as a member of any branch of the armed forces of the United States may be accepted by the Commissioner as evidence of satisfaction of the requirements for certification.

B. Each person desiring certification as an emergency medical services provider shall apply to the Commissioner upon a form prescribed by the Board. Upon receipt of such application, the Commissioner shall cause the applicant to be examined or otherwise determined to be qualified for

certification. When determining whether an applicant is qualified for certification, the Commissioner shall consider and may accept relevant practical experience and didactic and clinical components of education and training completed by an applicant during his service as a member of any branch of the armed forces of the United States as evidence of satisfaction of the requirements for certification. If the Commissioner determines that the applicant meets the requirements for certification as an emergency medical services provider, he shall issue a certificate to the applicant. An emergency medical services provider certificate so issued shall be valid for a period required by law or prescribed by the Board. Any certificate so issued may be suspended at any time that the Commissioner determines that the holder no longer meets the qualifications prescribed for such emergency medical services provider. The Commissioner may temporarily suspend any certificate without notice, pending a hearing or informal fact-finding conference, if the Commissioner finds that there is a substantial danger to public health or safety. When the Commissioner has temporarily suspended a certificate pending a hearing, the Commissioner shall seek an expedited hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.).

C. The Board shall prescribe by regulation procedures and the qualifications required for the recertification of emergency medical services providers.

D. The Commissioner may issue a temporary certificate when he finds that it is in the public interest. A temporary certificate shall be valid for a period not exceeding 90 days.

E. The Board shall require each person who, on or after July 1, 2013, applies to be a volunteer with or employee of an emergency medical services agency to submit fingerprints and provide personal descriptive information to be forwarded along with his fingerprints through the Central Criminal Records Exchange to the Federal Bureau of Investigation, for the purpose of obtaining his criminal history record information. The Central Criminal Records Exchange shall forward the results of the state and national records search to the Commissioner or his designee, who shall be a governmental entity. If an applicant is denied employment or service as a volunteer because of information appearing on his criminal history record and the applicant disputes the information upon which the denial was based, the Central Criminal Records Exchange shall, upon written request, furnish to the applicant the procedures for obtaining a copy of the criminal history record from the Federal Bureau of Investigation.

F. Notwithstanding the provisions of subsection E, an emergency medical services agency located in a locality having a local ordinance adopted in accordance with §§ 15.2-1503.1 and 19.2-389 shall require an applicant for employment or to serve as a volunteer to submit fingerprints and provide personal descriptive information to be provided directly to the Central Criminal Records Exchange to be forwarded to the Federal Bureau of Investigation for the purpose of obtaining criminal history records information for the applicant. The Central Criminal Records Exchange shall, upon receipt of an applicant's records or notification that no records exists, forward the results of the state and national records search to the county, city or town manager or chief law-enforcement officer for the locality in which the agency is located, or his designee, who shall be associated with a governmental entity. Upon receipt of the results of the state and national criminal history records search, the county, city or town manager

or chief law-enforcement officer for the locality, or his designee, shall notify the Office of Emergency Medical Services regarding the applicant's eligibility for employment or to serve as a volunteer. Information provided to the Office of Emergency Medical Services shall be limited to notification as to whether the applicant is eligible for employment or to serve as a volunteer in accordance with requirements related to disqualifying offenses set forth in regulations of the Board and shall not include information regarding whether the applicant has been found ineligible for employment or to serve as a volunteer due to additional exclusionary criteria established by the locality. Whenever fingerprints are submitted to both authorities and it is deemed feasible and practical by the Central Criminal Records Exchange it shall forward the results of the fingerprint based state and national records search to the county, city or town manager or chief law enforcement officer for the locality in which the agency is located, or his designee, who shall be associated with a governmental entity, and to the Office of Emergency Medical Services.

1996, c. 899; 1997, c. 248; 1998, cc. 803, 854; 2008, c. 660; 2011, c. 497; 2013, cc. 72, 176, 331, 407; 2015, cc. 362, 502, 503.

§ 32.1-111.5:1. Emergency medical services personnel mental health awareness training.

A. Each emergency medical services agency shall develop curricula for mental health awareness training for its personnel, which shall include training regarding the following:

1. Understanding signs and symptoms of cumulative stress, depression, anxiety, exposure to acute and chronic trauma, compulsive behaviors, and addiction;

2. Combating and overcoming stigmas;

3. Responding appropriately to aggressive behaviors such as domestic violence and harassment; and

4. Accessing available mental health treatment and resources.

B. Any emergency medical services agency may develop the mental health awareness training curricula in conjunction with other emergency medical services agencies or emergency medical services personnel stakeholder groups or may use any training program, developed by any entity, that satisfies the criteria set forth in subsection A.

C. Emergency medical services personnel who receive mental health awareness training in accordance with this section shall receive appropriate continuing education credits from the Office of Emergency Medical Services.

2018, cc. 456, 658.

§ 32.1-111.6. Emergency medical services agency license; emergency medical services vehicle permits.

A. No person shall operate, conduct, maintain, or profess to be an emergency medical services agency without a valid license issued by the Commissioner for such emergency medical services agency and a valid permit for each emergency medical services vehicle used by such emergency medical services agency.

B. The Commissioner shall issue an original or renewal license for an emergency medical services agency or renewal permit for an emergency medical services vehicle that meets all requirements set forth in this article and in the regulations of the Board, upon application, on forms and according to procedures established by the Board. Licenses and permits shall be valid for a period specified by the Board, not to exceed two years.

C. The Commissioner may issue (i) temporary licenses for emergency medical services agencies not meeting required standards, valid for a period not to exceed 60 days, and (ii) temporary permits for emergency medical services vehicles not meeting required standards, valid for a period of 90 days from the end of the month of issue, when the public interest will be served thereby.

D. The issuance of a license or permit in accordance with this section shall not be construed to authorize any emergency medical services agency to operate any emergency medical services vehicle without a franchise, license, or permit in any county or municipality that has enacted an ordinance pursuant to § 32.1-111.14 making it unlawful to do so.

E. The word "ambulance" shall not appear on any vehicle, vessel, or aircraft that does not hold a valid permit as an emergency medical services vehicle.

1996, c. 899; 2015, cc. 502, 503; 2018, c. 279.

§ 32.1-111.6:1. Commissioner to issue certain emergency medical services licenses or permits.

The Commissioner of Health shall issue licenses to emergency medical services agencies and permits for emergency medical services vehicles as needed to ensure compliance with federal regulations relating to reimbursement of emergency medical services vehicle transportation services pursuant to Medicare and Medicaid.

2004, c. 139; 2015, cc. 502, 503.

§ 32.1-111.7. Inspections.

Each emergency medical services agency for which a license has been issued and emergency medical services vehicle for which a permit has been issued shall be inspected as often as the Commissioner deems necessary and a record thereof shall be maintained. However, no emergency medical services agency or vehicle shall receive additional inspections until every other emergency medical services agency or vehicle in the Commonwealth has been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations, (ii) required by a uniformly applied risk-based schedule established by the Department, (iii) necessary to investigate a complaint regarding the emergency medical services agency or vehicle, or (iv) otherwise deemed necessary by the Commissioner or his designee to protect the health and safety of the public. Each such emergency medical services agency or emergency medical services vehicle, its medical supplies and equipment, and the records of its maintenance and operation shall be available at all reasonable times for inspection.

1996, c. 899; 2015, cc. 502, 503; 2017, c. 465.

§ 32.1-111.8. Revocation and suspension of licenses and permits.

Whenever an emergency medical services agency or emergency medical services vehicle owned or operated by an emergency medical services agency is in violation of any provision of this article or any applicable regulation, the Commissioner shall have power to revoke or suspend such emergency medical services agency's license and the permits of all emergency medical services vehicles owned or operated by the emergency medical services agency. The Commissioner may temporarily suspend any license for an emergency medical services agency or permit for an emergency medical services vehicle without notice, pending a hearing or informal fact-finding conference, if the Commissioner finds that there is a substantial danger to public health or safety. When the Commissioner has temporarily suspended a license or permit pending a hearing, the Commissioner shall seek an expedited hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.).

1996, c. 899; 2008, c. 660; 2015, cc. 502, 503.

§ 32.1-111.9. Applications for variances or exemptions.

A. Prior to the submission of (i) an application for a variance to the Commissioner or (ii) an application for an exemption from any regulations promulgated pursuant to this chapter to the Board by an emergency medical services agency that holds a valid license issued by the Commissioner, the application shall be reviewed by the governing body or chief administrative officer of the jurisdiction in which the principal office of the emergency medical services agency is located. The recommendation of the governing body or chief administrative officer of the jurisdiction regarding the variance or exemption shall be submitted with the application, and the Commissioner or Board, whichever is appropriate, shall consider that recommendation for the purposes of granting or denying the variance or exemption.

B. An individual who meets the definition of "emergency medical services personnel" in § 32.1-111.1 who is certified as an emergency medical services provider or is a candidate for certification by the Office of Emergency Medical Services shall not be required to submit an application for a variance or exemption to the local governing body or chief administrative officer of the jurisdiction for review, but shall submit the application for a variance or exemption to the Operational Medical Director and the emergency medical services agency chief with which he is affiliated, and shall include the recommendations of such Operational Medical Director and the emergency medical services agency chief together with the application for a variance or exemption. The recommendation of the Operational Medical Director and the emergency medical services agency chief with which the emergency medical services personnel is affiliated regarding the variance or exemption shall be submitted with the application and the Commissioner or Board, whichever is appropriate, shall consider that recommendation for the purposes of granting or denying the variance or exemption.

C. An emergency medical services provider who is not affiliated with an emergency medical services agency shall submit an application for a variance or exemption to the Commissioner or Board, whichever is appropriate, and the Commissioner or Board, whichever is appropriate, shall consider the application for the purposes of granting or denying the variance or exemption. The Commissioner or Board, whichever is appropriate, may require an emergency medical services provider who is not

affiliated with an emergency medical services agency to submit additional case-specific endorsements or supporting documentation as part of an application for a variance or exemption.

D. The applicant shall have the right to appeal any denial by the Commissioner or Board of an application for a variance or exemption pursuant to the Administrative Process Act (§ 2.2-4000 et seq.).

1996, c. 899; 2008, c. 61; 2011, c. 90; 2015, cc. 502, 503.

§ 32.1-111.9:1. Out-of-state emergency medical services providers.

A. Notwithstanding the provisions of this article or any other law or regulation to the contrary, an emergency medical services provider who holds a valid license or certification in a state that borders the Commonwealth may provide emergency medical services in the Commonwealth if (i) such services are provided at a widely attended event open to the public; (ii) due to the expected number of attendees, the anticipated need for emergency medical services at the event is beyond the capacity of local emergency medical services providers; (iii) the organizers of the event notify the Commissioner at least 10 business days prior to the event that out-of-state emergency medical services providers will be onsite at the event; and (iv) the out-of-state medical services providers provide to the Commissioner relevant licensure or certification information and any other information deemed necessary by the Commissioner.

B. The provisions of this section shall not be construed to supersede or affect the provisions of Chapter 18 (§ 32.1-371) or any other interstate agreement regarding emergency medical services providers. Any out-of-state emergency medical services provider who holds a license or certification in a state that has entered into an interstate compact of which the Commonwealth is a member or any other interstate agreement with the Commonwealth regarding emergency medical services providers shall be governed by the provisions of such compact or agreement.

2018, c. 196.

§§ 32.1-111.10, 32.1-111.11. Repealed.

Repealed by Acts 2015, cc. 502 and 503, cl. 2.

§ 32.1-111.12. Virginia Rescue Squads Assistance Fund; disbursements.

A. For the purpose of providing financial assistance to emergency medical services organizations in the Commonwealth, of providing the requisite training for emergency medical services personnel, and of purchasing equipment needed by such organizations, there is hereby created in the Department of the Treasury a special nonreverting fund that shall be known as the Virginia Rescue Squads Assistance Fund. The Fund shall be established on the books of the Comptroller, and any moneys remaining in such Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Interest earned on such moneys shall remain in the Fund and be credited to it. The Fund shall consist of any moneys appropriated for this purpose by the General Assembly and any other moneys received for such purpose by the Board. On and after July 1, 1996, any such moneys unexpended at the end of a fiscal biennium shall remain in the Fund and shall not revert to the general fund.

B. In accordance with regulations of the Board, the Commissioner shall disburse and expend the moneys in the Virginia Rescue Squads Assistance Fund. No moneys shall be disbursed directly to any emergency medical services organization unless such organization operates on a nonprofit basis exclusively for the benefit of the general public.

1996, c. 899; 2015, cc. 502, 503.

§ 32.1-111.12:01. Financial Assistance and Review Committee; appointment; terms; duties.

A. For the purposes of administering the Virginia Rescue Squads Assistance Fund as provided in § 32.1-111.12, there is hereby established the Financial Assistance and Review Committee. The Committee shall be composed of six members who shall be representatives of the regions encompassed by the emergency medical services councils and appointed by the State Emergency Medical Services Advisory Board. To ensure that each regional emergency medical services council is provided an opportunity to serve on the Committee, the Board of Health shall promulgate by regulation, after receiving the Advisory Board's recommendation, a cycle which provides for rotating geographic representation among the councils.

B. Members serving on the Financial Assistance and Review Committee on January 1, 1996, shall complete their current terms of office. Thereafter, appointments shall be made for terms of three years or the unexpired portions thereof in a manner to preserve, insofar as possible, the representation of the emergency medical services councils. No member may serve more than two successive terms. The chairman shall be elected from the membership of the Committee for a term of one year and shall be eligible for reelection. The Committee shall meet at least four times annually at the call of the chairman or the Commissioner.

C. The Financial Assistance and Review Committee shall:

1. Administer the Rescue Squads Assistance Fund in accordance with the rules and regulations of the State Board of Health as shall be established for the Fund;

2. Review the Rescue Squads Assistance Fund grant applications from eligible emergency medical services agencies and make recommendations on the funding of such grant applications to the Commissioner of Health; and

3. Report biannually, after each funding cycle, the number of grant applications received, the total costs of grant applications funded, the number of grant applications denied funding, the total costs of grant applications denied funding, and the nature of the denied requests and the reasons for denying funding, to the State Emergency Medical Services Advisory Board and the Commissioner.

1996, c. 998.

§ 32.1-111.13. Annual financial reports.

The Virginia Association of Volunteer Rescue Squads shall submit an annual financial report on the use of funds received from the special emergency medical services fund to the Advisory Board Exec-

utive Committee on such forms and providing such information as may be required by the Advisory Board Executive Committee for such purpose.

1996, c. 899; 2013, c. 517; 2015, cc. 502, 503.

§ 32.1-111.14. Powers of governing bodies of counties, cities, and towns.

A. Upon finding as fact, after notice and public hearing, that exercise of the powers enumerated below is necessary to assure the provision of adequate and continuing emergency medical services and to preserve, protect and promote the public health, safety and general welfare, the governing body of any county or city is empowered to:

1. Enact an ordinance making it unlawful to operate any emergency medical services vehicle or class thereof established by the Board in such county or city without having been granted a franchise, license or permit to do so;

2. Grant franchises, licenses or permits to emergency medical services agencies based within or outside the county or city; however, any emergency medical services agency in operation in any county or city on June 28, 1968, that continues to operate as such, up to and including the effective date of any ordinance adopted pursuant to this section, and that submits to the governing body of the county or city satisfactory evidence of such continuing operation, shall be granted a franchise, license or permit by such governing body to serve at least that part of the county or city in which the agency has continuously operated if all other requirements of this article are met;

3. Limit the number of emergency medical services vehicles to be operated within the county or city and by any emergency medical services agency;

4. Determine and prescribe areas of franchised, licensed or permitted service within the county or city;

5. Fix and change from time to time reasonable charges for franchised, licensed or permitted services;

6. Set minimum limits of liability insurance coverage for emergency medical services vehicles;

7. Contract with franchised, licensed or permitted emergency medical services agencies for emergency medical services vehicle transportation services to be rendered upon call of a county or municipal agency or department and for transportation of bona fide indigents or persons certified by the local board of social services to be public assistance or social services recipients; and

8. Establish other necessary regulations consistent with statutes or regulations of the Board relating to operation of emergency medical services vehicles.

B. In addition to the powers set forth above, the governing body of any county or city is authorized to provide, or cause to be provided, services of emergency medical services vehicles; to own, operate and maintain emergency medical services vehicles; to make reasonable charges for use of emergency medical services vehicles, including charging insurers for emergency medical services vehicle transportation services as authorized by § 38.2-3407.9; and to contract with any emergency medical services agency for the services of its emergency medical services vehicles.

C. Any incorporated town may exercise, within its corporate limits only, all those powers enumerated in subsections A and B either upon the request of a town to the governing body of the county wherein the town lies and upon the adoption by the county governing body of a resolution permitting such exercise, or after 180 days' written notice to the governing body of the county if the county is not exercising such powers at the end of such 180-day period.

D. No county ordinance enacted, or other county action taken, pursuant to powers granted herein shall be effective within an incorporated town in such county which is at the time exercising such powers until 180 days after written notice to the governing body of the town.

E. Nothing herein shall be construed to authorize any county to regulate in any manner emergency medical services vehicles owned and operated by a town or to authorize any town to regulate in any manner emergency medical services vehicles owned and operated by a county.

F. Emergency medical services vehicles operated by a county, city, or town under authority of this section shall be subject to the provisions of this article and to the regulations of the Board.

1996, c. 899; 2002, c. 747; 2005, c. 182; 2015, cc. 502, 503.

§ 32.1-111.14:1. Repealed.

Repealed by Acts 2003, c. 978, cl. 2, effective April 2, 2003.

§ 32.1-111.14:2. Establishment of emergency medical services zones or districts; tax levies.

The governing bodies of the several counties or cities of the Commonwealth may create and establish, by designation on a map of the county or city showing current, official parcel boundaries, or by any other description that is legally sufficient for the conveyance of property or the creation of parcels, emergency medical services zones or districts in such counties or cities within which may be located and established one or more emergency medical services agencies for providing emergency medical services within such zones or districts.

In the event of the creation of such zones or districts in any county or city, the county or city governing body may acquire, in the name of the county or city, real or personal property to be devoted to the uses aforesaid and shall prescribe rules and regulations for the proper management, control, and conduct thereof. Such governing body shall also have authority to contract with, or secure the services of, any individual corporation, organization, or municipal corporation or any volunteer emergency medical services agency or emergency medical services provider for such emergency medical services as may be required.

To raise funds for the purposes aforesaid, the governing body of any county or city in which such zones or districts are established may levy annually a tax on the assessed value of all property, real and personal, within such zones or districts, subject to local taxation, which tax shall be extended and collected as other county or city taxes are extended and collected. However, any property located in Augusta County that has qualified for an agricultural or forestal use-value assessment pursuant to Article 4 (§ 58.1-3229 et seq.) of Chapter 32 of Title 58.1 may not be included within such a zone or

district and may not be subject to such tax. In any county or city having a population between 25,000 and 25,500, the maximum rate of tax under this section shall be $0.30 on $100 of assessed value.

The amount realized from such levy shall be kept separate from all other moneys of the county or city and shall be applied to no other purpose than the maintenance and operation of the emergency medical services agencies established pursuant to this section.

2015, cc. 502, 503.

§ 32.1-111.14:3. Exclusion of certain areas from emergency medical services zones or districts and exemption of such areas from certain levies.

The governing body of any county or city having an emergency medical services zone or district created under the provisions of § 32.1-111.14:2, prior to June 1 of any calendar year, may alter the boundaries of such emergency medical services zone or district for the purpose of excluding an area of any such emergency medical services zone or district that is also within the boundaries of a sanitary district providing emergency medical services or under contract to a sanitary district providing emergency medical services.

Any area excluded from an emergency medical services zone or district as provided by this section shall not be subject to the levy set forth in § 32.1-111.14:2 for the year such area is excluded.

2015, cc. 502, 503.

§ 32.1-111.14:4. Advances by county or city to emergency medical services zone or district; reimbursement; validation of prior advances.

A. The governing body of any county or city in the Commonwealth may advance funds, not otherwise specifically allocated or obligated, from the general fund to an emergency medical services zone or district to assist the emergency medical services zone or district to exercise the powers set forth in § 32.1-111.14:2.

B. Notwithstanding the provisions of any other law, the governing body shall direct the treasurer to reimburse the general fund of the county or city from the proceeds of any funds to the credit of the emergency medical services zone or district, not otherwise specifically allocated or obligated, to the extent that the county or city has made advances to the emergency medical services zone or district from such general fund to assist the emergency medical services zone or district to exercise the powers set forth in § 32.1-111.14:2.

C. The advancement of any funds heretofore advanced from the general fund by the governing body of any county or city in the Commonwealth for the benefit of an emergency medical services zone or district in exercising the lawful powers of such emergency medical services zone or district is hereby validated and confirmed.

2015, cc. 502, 503.

§ 32.1-111.14:5. Authority of emergency medical services agency incident commander when operating at an emergency incident; penalty for refusal to obey orders.

Except as provided in § 32.1-111.14:6, while any emergency medical services personnel are in the process of operating at an emergency incident where there is imminent danger and when emergency medical services personnel are returning to the emergency medical services agency, the incident commander of such emergency medical services agency at that time shall have the authority to (i) maintain order at such emergency incident or its vicinity, (ii) direct the actions of emergency medical services personnel at the incident, (iii) notwithstanding the provisions of §§ 46.2-888 through 46.2-891, keep bystanders or other persons at a safe distance from the incident and emergency equipment, (iv) facilitate the speedy movement and operation of emergency equipment and emergency medical services personnel, and (v) until the arrival of a police officer, direct and control traffic in person or by deputy and facilitate the movement of traffic. The emergency medical services agency incident commander shall display his emergency medical services personnel's badge or other proper means of identification. Notwithstanding any other provision of law, this authority shall extend to the activation of traffic control signals designed to facilitate the safe egress and ingress of emergency equipment at an emergency medical services agency. Any person refusing to obey the orders of the emergency medical services incident commander at that time is guilty of a Class 4 misdemeanor. The authority granted under the provisions of this section may not be exercised to inhibit or obstruct members of law-enforcement agencies or fire departments or fire companies from performing their normal duties when operating at such emergency incident, nor to conflict with or diminish the lawful authority, duties, and responsibilities of forest wardens, including but not limited to the provisions of Chapter 11 (§ 10.1-1100 et seq.) of Title 10.1. Personnel from the news media, such as the press, radio, and television, when gathering the news may enter at their own risk into the incident area only when the incident commander has deemed the area safe and only into those areas of the incident that do not, in the opinion of the incident commander, interfere with the emergency medical services personnel dealing with such emergencies, in which case the emergency medical services incident commander may order such person from the scene of the emergency incident.

2015, cc. 502, 503.

§ 32.1-111.14:6. Supervision and control of joint services of emergency medical services agencies.

Whenever two or more emergency medical services agencies are called to provide joint services in any district or political subdivision, the incident commander of the first agency to arrive shall have general supervision and control of all such participating agencies until an officer of such district or political subdivision who is otherwise authorized by law to do so shall assume such general supervision and control.

2015, cc. 502, 503.

§ 32.1-111.14:7. Penalty for disobeying emergency medical services agency chief or other officer in command.

If any person at a fire or medical emergency refuses or neglects to obey any order duly given by the individual having command of the incident in accordance with § 32.1-111.14:5 or 32.1-111.14:6, he shall, upon conviction of such offense, be fined not to exceed $100.

2015, cc. 502, 503.

§ 32.1-111.14:8. Purchase, maintenance, etc., of equipment; donated equipment.

A. The governing body of every county, city, or town shall have power to provide for the purchase, operation, staffing, and maintenance of suitable equipment for providing emergency medical services in or upon the property of the county, city, or town and of its inhabitants and to prescribe the terms and conditions upon which the same will be used for providing emergency medical services in or upon privately owned property.

B. Any emergency medical services agency donating equipment for providing emergency medical services to any other emergency medical services agency, which equipment met existing engineering and safety standards at the time of its purchase by the donating entity, shall be immune from civil liability unless the donating entity acted with gross negligence or willful misconduct.

C. A safety inspection must be completed by a certified emergency medical services vehicle service center and a report designating any deficiencies shall be provided prior to the change in ownership of the donated emergency medical services vehicle.

2015, cc. 502, 503.

§ 32.1-111.14:9. Entry of buildings and premises adjoining during a medical emergency.

A. The incident commander at a medical emergency, and his subordinates, upon his order or direction, shall have the right at any time of the day or night to enter any building or upon any premises where a medical emergency is in progress, or any building or premises adjacent thereto for the purpose of providing emergency medical services.

B. The incident commander at a medical emergency, and his subordinates upon his order or direction, shall have the right to remain at the scene of a medical emergency, including remaining in any building or house, for purposes of protecting the property and preventing the public from entry into the premises, until such reasonable time as the owner may resume responsibility for the protection of the property.

2015, cc. 502, 503.

§ 32.1-111.15. Statewide poison control system established.

From such funds as may be appropriated for this purpose and from such gifts, donations, grants, bequests, and other funds as may be received, the Board shall establish a statewide poison control system. The funding mechanism for the system and its services shall be as provided in the appropriation act.

The Board shall establish poison control centers that meet national certification standards promulgated by the American Association of Poison Control Centers. If such national certification standards are eliminated, the Board shall establish minimum standards for the designation and operation of these poison control centers. The poison control centers established by the Board shall report to the Board by October 1 of each year regarding program operations; expenditures; revenues, including in-

kind contributions; financial status; future needs; and summaries of human poison exposure cases for the most recent calendar year.

The statewide system shall provide, at a minimum, (i) consultation, by free, 24-hour emergency telephone or other means of communication, to the public and to health care providers regarding the ingestion or application of substances, including determinations of emergency treatment, coordination of referrals to emergency treatment facilities, and provision of appropriate information to the staffs of such facilities; (ii) prevention education and information about poison control services; (iii) training for health care providers in toxicology and medical management of poison exposure cases; and (iv) poison control surveillance through the collection and analysis of data from reported poison exposures to identify poisoning hazards, prevent poisonings, and improve treatment of poisoned patients.

1996, c. 899; 2015, cc. 502, 503.

§ 32.1-111.15:1. Department responsible for stroke care quality improvement; sharing of data and information.

A. The Department shall be responsible for stroke care quality improvement initiatives in the Commonwealth. Such initiatives shall include:

1. Implementing systems to collect data and information about stroke care in the Commonwealth in accordance with subsection B;

2. Facilitating information and data sharing and collaboration among hospitals and health care providers to improve the quality of stroke care in the Commonwealth;

3. Requiring the application of evidence-based treatment guidelines for transitioning patients to community-based follow-up care following acute treatment for stroke; and

4. Establishing a process for continuous quality improvement for the delivery of stroke care by the statewide system for stroke response and treatment in accordance with subsection C.

B. The Department shall implement systems to collect data and information related to stroke care (i) that are nationally recognized data set platforms with confidentiality standards approved by the Centers for Medicare and Medicaid Services or consistent with the Get With The Guidelines-Stroke registry platform from hospitals designated as comprehensive stroke centers, primary stroke centers, or acute stroke-ready hospitals and emergency medical services agencies in the Commonwealth and (ii) from every primary stroke center with supplementary levels of stroke care distinction in the Commonwealth. Every hospital designated as a comprehensive stroke center, primary stroke center, or primary stroke center with supplementary levels of stroke care distinction shall report data and information described in clauses (i) and (ii) to the Department. The Department shall take steps to encourage hospitals designated as acute stroke-ready hospitals and emergency medical services agencies to report data and information described in clause (i) to the Department.

C. The Department shall develop a process for continuous quality improvement for the delivery of stroke care provided by the statewide system for stroke response and treatment, which shall include:

1. Collection and analysis of data related to stroke care in the Commonwealth;

2. Identification of potential interventions to improve stroke care in specific geographic areas of the Commonwealth; and

3. Development of recommendations for improvement of stroke care throughout the Commonwealth.

D. The Department shall make information contained in the systems established pursuant to subsection B and data and information collected pursuant to subsection C available to licensed hospitals and the Virginia Stroke Systems Task Force, and, upon request, to emergency medical services agencies, regional emergency medical services councils, the State Emergency Medical Services Advisory Board, and other entities engaged in the delivery of emergency medical services in the Commonwealth to facilitate the evaluation and improvement of stroke care in the Commonwealth.

E. The Department shall report to the Governor and the General Assembly annually on July 1 on stroke care improvement initiatives undertaken in accordance with this section. Such report shall include a summary report of the data collected pursuant to this section.

F. Nothing in this article shall require or authorize the disclosure of confidential information in violation of state or federal law or regulations, including the Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d et seq.

2018, cc. 198, 276.

Article 2.2 - EVALUATION OF DIRECTOR OF OFFICE OF EMERGENCY MEDICAL SERVICES

§ 32.1-111.16. Director of Office of Emergency Medical Services annual performance evaluation.
Effective on and after July 1, 1996, the Commissioner of Health, in consultation with the State Emergency Medical Services Advisory Board, shall annually review and evaluate the performance of the Director of the Office of Emergency Medical Services. The Commissioner shall consider the Director's effectiveness in operating and managing the programs, services, and personnel, of the Office of Emergency Medical Services and the statewide emergency medical care system established in Article 2.1 (§ 32.1-111.1 et seq.) of this chapter; any recommendations of the Advisory Board; and such other relevant information as may be made available to the Commissioner pertaining to the Director's performance of his duties.

1996, c. 192.

Article 3 - STATEWIDE EMERGENCY MEDICAL CARE SYSTEM

§§ 32.1-112 through 32.1-116.01. Repealed.
Repealed by Acts 1996, c. 899.

Article 3.1 - Emergency Medical Services Patient Care Information System

§ 32.1-116.1. Prehospital patient care reporting procedure; trauma registry; confidentiality.

A. In order to collect data on the incidence, severity, and cause of trauma; integrate the information available from other state agencies on trauma; improve the delivery of prehospital and hospital emergency medical services, the quality of patient care, and access to medical services; and make other system improvements, there is hereby established the Emergency Medical Services Patient Care Information System. The Emergency Medical Services Patient Care Information System shall include the Virginia Emergency Medical Services (EMS) Registry and the Virginia Statewide Trauma Registry.

B. All licensed emergency medical services agencies shall participate in the Virginia EMS Registry by making available to the Commissioner or his designees the minimum data set in the format prescribed by the Board or any other format which contain equivalent information and meets any technical specifications of the Board. The minimum data set shall include, but not be limited to, the type of medical emergency or nature of the call, the response time, the treatment provided and other items as prescribed by the Board.

Each licensed emergency medical services agency shall, upon request, disclose the prehospital care report to law-enforcement officials (i) when the patient is the victim of a crime or (ii) when the patient is in the custody of the law-enforcement officials and has received emergency medical services or has refused emergency medical services.

The Commissioner may delegate the responsibility for collection of this data to the Office of Emergency Medical Services personnel or individuals under contract to the Office. The Advisory Board shall assist in the design, implementation, subsequent revisions and analyses of the data from the Virginia EMS Registry.

C. All licensed hospitals which render emergency medical services shall participate in the Virginia Statewide Trauma Registry by making available to the Commissioner or his designees abstracts of the records of all patients admitted to the institutions with diagnoses related to trauma. The abstracts shall be submitted in the format prescribed by the Department and shall include the minimum data set prescribed by the Board. Such abstracts shall also be provided to regional emergency medical services councils upon request, for uses limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-111.3.

The Commissioner shall seek the advice and assistance of the Advisory Board and the Trauma System Oversight and Management Committee in the design, implementation, subsequent revisions and analyses of the Virginia Statewide Trauma Registry.

D. Patient and other data or information submitted to the trauma registry 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, permitted emergency medical services agency, or other group or committee for the purpose of monitoring and improving the quality of care pursuant to § 32.1-111.3, shall be privileged and shall not be disclosed or obtained by legal discovery proceedings, unless disclosure is made in accordance with § 32.1-116.2 or a circuit

court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

E. The Commissioner shall make available and share all information contained in the Virginia Statewide Trauma Registry with the Department for Aging and Rehabilitative Services so that the Department may develop and implement programs and services for persons suffering from brain injuries and spinal cord injuries.

1987, c. 480; 2002, cc. 568, 658; 2003, c. 471; 2006, c. 412; 2007, c. 13; 2008, c. 563; 2012, cc. 402, 803, 835; 2018, c. 195; 2020, c. 883.

§ 32.1-116.1:1. Disclosure of medical records.

Any licensed physician, licensed health care provider, or licensed health care facility may disclose to emergency medical services personnel, an emergency medical services physician, or their licensed parent agency the medical records of a sick or injured person to whom such emergency medical services personnel or emergency medical services physician is providing or has rendered emergency medical care for the purpose of promoting the medical education of the specific person who provided such care or for quality improvement initiatives of their agency or of the emergency medical services system as a whole. Any emergency medical services personnel or emergency medical services physician to whom such confidential records are disclosed shall not further disclose such information to any persons not entitled to receive that information in accordance with the provisions of this section.

1988, c. 486; 2007, c. 13; 2008, c. 118; 2015, cc. 502, 503.

§ 32.1-116.1:2. Expired.

Expired.

§ 32.1-116.2. Confidential nature of information supplied; publication; liability protections.

A. The Commissioner and all other persons to whom data is submitted shall keep patient information confidential. Mechanisms for protecting patient data shall be developed and continually evaluated to ascertain their effectiveness. No publication of information, research or medical data shall be made which identifies the patients by names or addresses, except as specified in subsection B. The Commissioner or his designees may utilize institutional data in order to improve the quality of and appropriate access to emergency medical services and to improve the health of citizens of the Commonwealth.

B. In accordance with the State Board of Health's regulations and applicable federal law and regulations, the Commissioner may disclose information, research, or medical data that identifies patients by name or address if the Commissioner determines that such disclosure is necessary to develop and implement programs that improve the quality of patient care, improve access to medical services, or make other system improvements. The Commissioner shall only disclose such information with entities, including but not limited to other Virginia state agencies and programs, federal agencies and programs, the National Registry of Emergency Medical Technicians, or recognized research institutions

and organizations, that seek to improve quality of care, improve access to medical services, or make other system improvements.

C. No individual, licensed emergency medical services agency, hospital, Regional Emergency Medical Services Council or organization advising the Commissioner shall be liable for any civil damages resulting from any act or omission preformed as required by this article unless such act or omission was the result of gross negligence or willful misconduct.

1987, c. 480; 2020, c. 883.

§ 32.1-116.3. Reporting of communicable diseases; definitions.

A. For the purposes of this section:

"Communicable disease of public health threat" means an illness of public health significance, as determined by the State Health Commissioner in accordance with regulations of the Board of Health, caused by a specific or suspected infectious agent that may be reasonably expected or is known to be readily transmitted directly or indirectly from one individual or person to another or to uninfected persons through airborne or nonairborne means and has been found to create a risk of death or significant injury or impairment; this definition shall not, however, be construed to include human immunodeficiency viruses or tuberculosis, unless used as a bioterrorism weapon. "Individual" shall include any companion animal.

"Communicable diseases" means any airborne infection or disease, including, but not limited to, tuberculosis, measles, certain meningococcal infections, mumps, chicken pox and Hemophilus Influenzae Type b, and those transmitted by contact with blood or other human body fluids, including, but not limited to, human immunodeficiency virus, Hepatitis B and Non-A, Non-B Hepatitis.

B. Every licensed health care facility that transfers or receives patients via emergency medical services vehicles shall notify the emergency medical services agencies providing such patient transport of the name and telephone number of the individual who is the infection control practitioner with the responsibility of investigating exposure to infectious diseases in the facility.

Every emergency medical services agency that holds a valid license issued by the Commissioner and that is established in the Commonwealth shall notify all facilities to which it transports patients or from which it transfers patients of the names and telephone numbers of the members, not to exceed three persons, who have been appointed to serve as the exposure control officers. Every emergency medical services agency that holds a valid license issued by the Commissioner shall implement universal precautions and shall ensure that these precautions are appropriately followed and enforced.

C. Upon requesting any emergency medical services agency that holds a valid license issued by the Commissioner to transfer a patient who is known to be positive for or who suffers from any communicable disease, the transferring facility shall inform the attendant-in-charge of the transferring crew of the general condition of the patient and the types of precautions to be taken to prevent the spread of the disease. The identity of the patient shall be confidential.

D. If any firefighter, law-enforcement officer, or emergency medical services provider has an exposure of blood or body fluid to mucous membrane or non-intact skin or a contaminated needlestick injury, his exposure control officer shall be notified, a report completed, and the infection control practitioner at the receiving facility notified.

E. If, during the course of medical care and treatment, any physician determines that a patient who was transported to a receiving facility by any emergency medical services agency that holds a valid license issued by the Commissioner (i) is positive for or has been diagnosed as suffering from an airborne infectious disease or (ii) is subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2, then the infection control practitioner in the facility shall immediately notify the exposure control officer who represents the transporting emergency medical services agency of the name of the patient and the date and time of the patient's admittance to the facility. The exposure control officer for the transporting emergency medical services agency shall investigate the incident to determine if any exposure of emergency medical services personnel or other emergency personnel occurred. The identity of the patient and all personnel involved in any such investigation shall be confidential.

F. If any firefighter, law-enforcement officer, or emergency medical services provider is exposed to a communicable disease, the exposure control officer shall immediately notify the infection control practitioner of the receiving facility. The infection control practitioner of the facility shall conduct an investigation and provide information concerning the extent and severity of the exposure and the recommended course of action to the exposure control officer of the transporting agency.

G. Any person requesting or requiring any employee of a public safety agency as defined in subsection M of § 32.1-45.2 to arrest, transfer, or otherwise exercise custodial supervision over an individual known to the requesting person (i) to be infected with any communicable disease or (ii) to be subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 shall inform such public safety agency employee of a potential risk of exposure to a communicable disease.

H. Local or state correctional facilities which transfer patients known to have a communicable disease or to be subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 shall notify the emergency medical services agency providing transportation services of a potential risk of exposure to a communicable disease, including a communicable disease of public health threat. For the purposes of this section, the chief medical person at a local or state correctional facility or the facility director or his designee shall be responsible for providing such information to the transporting agency.

I. Any person who, as a result of this provision, becomes aware of the identity or condition of a person known to be (i) positive for or to suffer from any communicable disease, or to have suffered exposure to a communicable disease or (ii) subject to an order of quarantine or an order of isolation pursuant to

Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2, shall keep such information confidential, except as expressly authorized by this provision.

J. No person known to be (i) positive for or to suffer from any communicable disease, including any communicable disease of public health threat, or (ii) subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2, shall be refused transportation or service for that reason by an emergency medical services, law-enforcement, or public safety agency.

1988, cc. 760, 789; 1989, c. 443; 1993, c. 655; 2004, cc. 773, 1021; 2008, c. 118; 2009, cc. 478, 552; 2015, cc. 502, 503; 2020, c. 502.

Article 4 - HEALTH PLANNING AND RESOURCES DEVELOPMENT

§§ 32.1-117 through 32.1-122. Repealed.

Repealed by Acts 1989, cc. 617, 633.

Article 4.1 - HEALTH PLANNING AND RESOURCES DEVELOPMENT

§ 32.1-122.01. Definitions.

As used in this article unless the context requires a different meaning:

"Board" means the State Board of Health.

"Commissioner" means the State Health Commissioner.

"Consumer" means a person who is not a provider of health care services.

"Department" means the Virginia Department of Health.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons, which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Provider" means a licensed or certified health care practitioner, a licensed health care facility or service administrator, or an individual who has a personal interest in a health care facility or service as defined in the Virginia Conflict of Interests Act (§ 2.2-3100 et seq.).

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Board to perform the health planning activities set forth in this chapter within a health planning region.

"Regional health planning board" means the governing board of the regional health planning agency as described in § 32.1-122.05.

"Secretary" means the Secretary of Health and Human Resources of the Commonwealth of Virginia.

"State Health Plan" means the document so designated by the Board, which may include analysis of priority health issues, policies, needs, methodologies for assessing statewide health care needs, and such other matters as the Board shall deem appropriate.

"Tertiary care" means health care delivered by facilities that provide specialty acute care including, but not limited to, trauma care, neonatal intensive care and cardiac services.

1989, cc. 617, 633; 2002, c. 83.

§ 32.1-122.02. Repealed.

Repealed by Acts 2002, c. 83.

§ 32.1-122.03. State Health Plan.

A. The Board may develop, and revise as it deems necessary, the State Health Plan with the support of the Department and the assistance of the regional health planning agencies. Following review and comment by interested parties, including appropriate state agencies, the Board may develop and approve the State Health Plan. The State Health Plan shall be developed in accordance with components and methodologies that take into account special needs or circumstances of local areas. The Plan shall reflect data and analyses provided by the regional health planning agencies and include regional differences where appropriate. The Board, in preparation of the State Health Plan and to avoid unnecessary duplication, may consider and utilize all relevant and formally adopted plans of agencies, councils, and boards of the Commonwealth.

B. In order to develop and approve the State Health Plan, the Board may conduct such studies as may be necessary of critical health issues as identified by the Governor, General Assembly, Secretary or by the Board. Such studies may include, but not be limited to: (i) collection of data and statistics; (ii) analyses of information with subsequent recommendations for policy development, decision making and implementation; and (iii) analyses and evaluation of alternative health planning proposals and initiatives.

1989, cc. 617, 633; 2002, c. 83.

§ 32.1-122.03:1. Statewide Telehealth Plan.

A. As used in this section:

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

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

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

B. The Board shall amend and maintain, in consultation with the Virginia Telehealth Network, as a component of the State Health Plan a Statewide Telehealth Plan to promote an integrated approach to the introduction and use of telehealth services and telemedicine services. The Board shall contract

with the Virginia Telehealth Network, or another Virginia-based nongovernmental, nonprofit organization focused on telehealth if the Virginia Telehealth Network is no longer in existence, to (i) provide direct consultation to any advisory groups and groups tasked by the Board with implementation and data collection as required by this section, (ii) track implementation of the Statewide Telehealth Plan, and (iii) facilitate changes to the Statewide Telehealth Plan as accepted medical practices and technologies evolve.

C. The Statewide Telehealth Plan shall include but not be limited to provisions for:

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

2. The promotion of the use of remote patient monitoring services and store-and-forward technologies, including in cases involving patients with chronic illness;

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

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

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

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

2020, c. 729; 2022, cc. 724, 742.

§ 32.1-122.04. Responsibilities of the Department.

The Department shall have the following responsibilities as directed by the Board:

1. To conduct the research for the health planning activities of the Commonwealth.

2. To prepare, review and revise the State Health Plan when so directed by the Board.

3. To develop, under the direction of the Board and with the cooperation of the regional health planning agencies, the components and methodology for the State Health Plan, including any research, issue analyses and related reports.

4. To provide technical assistance to the regional health planning agencies.

5. To perform such other functions relating to health planning in the Commonwealth as may be requested by the Governor or the Secretary.

1989, cc. 617, 633; 2002, c. 83.

§ 32.1-122.05. Regional health planning agencies; boards; duties and responsibilities.

A. For the purpose of representing the interests of health planning regions and performing health planning activities at the regional level, there are hereby created such regional health planning agencies as may be designated by the Board of Health.

B. Each regional health planning agency shall be governed by a regional health planning board to be composed of not more than thirty residents of the region. The membership of the regional health planning boards shall include, but not be limited to, consumers, providers, a director of a local health department, a director of a local department of social services or welfare, a director of a community services board, a director of an area agency on aging and representatives of health care insurers, local governments, the business community and the academic community. The majority of the members of each regional health planning board shall be consumers. Consumer members shall be appointed in a manner that ensures the equitable geographic and demographic representation of the region. Provider members shall be solicited from professional organizations, service and educational institutions and associations of service providers and health care insurers in a manner that assures equitable representation of provider interest.

The members of the regional health planning boards shall be appointed for no more than two consecutive terms of four years or, when appointed to fill an unexpired term of less than four years, for three consecutive terms consisting of one term of less than four years and two terms of four years. The boards shall not be self-perpetuating. The Board of Health shall establish procedures requiring staggered terms. The composition and the method of appointment of the regional health planning boards shall be established in the regulations of the Board of Health. In addition, the Board of Health shall require, pursuant to regulations, each regional health planning board to report and maintain a record of its membership, including, but not limited to, the names, addresses, dates of appointment, years served, number of consecutive and nonconsecutive terms, and the group represented by each member. These membership reports and records shall be public information and shall be published in accordance with the regulations of the Board.

C. An agreement shall be executed between the Commissioner, in consultation with the Board of Health, and each regional health planning board to delineate the work plan and products to be developed with state funds. Funding for the regional health planning agencies shall be contingent upon meeting these obligations and complying with the Board's regulations.

D. Each regional health planning agency shall assist the Board of Health by: (i) conducting data collection, research and analyses as required by the Board; (ii) preparing reports and studies in consultation and cooperation with the Board; (iii) reviewing and commenting on the components of the State Health Plan; (iv) conducting needs assessments as appropriate and serving as a technical resource to the Board; (v) identifying gaps in services, inappropriate use of services or resources and assessing accessibility of critical services; (vi) reviewing applications for certificates of public need and making recommendations to the Department thereon as provided in § 32.1-102.6; and (vii) conducting such other functions as directed by the regional health planning board. All regional health planning agencies shall demonstrate and document accountability for state funds through annual budget projections and quarterly expenditure and activity reports that shall be submitted to the Commissioner. A regional health planning agency may designate membership and activities at subarea levels as deemed appropriate by its regional health planning board. Each regional health planning board shall adopt bylaws for its operation and for the election of its chairman and shall maintain and publish a record of its membership and any subarea levels as required by this section and the regulations of the Board of Health.

1989, cc. 617, 633; 2002, cc. 83, 398.

§ 32.1-122.06. Funds for regional health planning.

In the interest of maintaining a regional health planning mechanism in the Commonwealth, there is hereby established funding for regional health planning. From such moneys as may be available and appropriated, this fund shall provide support of a maximum of fifteen cents per capita for each regional health planning agency as may be designated. Per capita population figures shall be obtained from official population estimates. This funding may be used for the administration of the regional health

planning agency, the analysis of issues, and such other health planning purposes as may be requested.

Any local governing body may choose to appropriate funds for the purpose of providing additional funds for a regional health planning agency. However, nothing in this section shall place any obligation on any local governing body to appropriate funds to any regional health planning agency.

Each regional health planning agency shall be required to apply to the Department for funding, which shall be distributed as grants. This funding shall be administered by the Department, and the Board shall promulgate regulations as are necessary and relevant to administer the funding. All applications for such funding shall be accompanied by letters of assurance that the applicant shall comply with all state requirements.

For purposes of this section, regional health planning agencies in existence as of July 1, 2002, shall be retained as designated regional health planning agencies unless (i) the Board, pursuant to its regulations, revises such designations, or (ii) any individual regional health planning agency ceases operation or the designation as a regional health planning agency is otherwise terminated in accordance with the agreement between the regional health planning agency and the Board.

The extent to which grants are awarded from this fund shall be dependent upon the amount of money appropriated to implement the provisions of this section.

1989, cc. 617, 633; 1990, c. 391; 2002, c. 83; 2009, c. 175.

§ 32.1-122.07. Authority of Commissioner for certain health planning activities; rural health plan; designation as a rural hospital.

A. The Commissioner, with the approval of the Board, is authorized to make application for federal funding and to receive and expend such funds in accordance with state and federal regulations.

B. The Commissioner shall administer section 1122 of the United States Social Security Act if the Commonwealth has made an agreement with the United States Secretary of Health and Human Services pursuant to such section.

C. In compliance with the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions, the Commissioner shall submit to the appropriate regional administrator of the Centers for Medicare & Medicaid Services (CMS) an application to establish a Medicare Rural Hospital Flexibility Program in Virginia.

D. The Commissioner shall develop and the Board of Health shall approve a rural health care plan for the Commonwealth to be included with the application to establish a Medicare Rural Hospital Flexibility Program. In cooperation and consultation with the Virginia Hospital and Health Care Association, the Medical Society of Virginia, representatives of rural hospitals, and experts within the Department of Health on rural health programs, the plan shall be developed and revised as necessary or as required by the provisions of the Balanced Budget Act of 1997, P.L. 105-33, and any amendments to such provisions. In the development of the plan, the Commissioner may also seek the

assistance of the regional health planning agencies. The plan shall verify that the Commonwealth is in the process of designating facilities located in Virginia as critical access hospitals, shall note that the Commonwealth wishes to certify facilities as "necessary providers" of health care in rural areas, and shall describe the process, methodology, and eligibility criteria to be used for such designations or certifications. Virginia's rural health care plan shall reflect local needs and resources and shall, at minimum, include, but need not be limited to, a mechanism for creating one or more rural health networks, ways to encourage rural health service regionalization, and initiatives to improve access to health services, including hospital services, for rural Virginians.

E. Notwithstanding any provisions of this chapter or the Board's regulations to the contrary, the Commissioner shall, in the rural health care plan, (i) use as minimum standards for critical access hospitals, the certification regulations for critical access hospitals promulgated by the Centers for Medicare & Medicaid Services (CMS) pursuant to Title XVIII of the Social Security Act, as amended; and (ii) authorize critical access hospitals to utilize a maximum of ten beds among their inpatient hospital beds as swing beds for the furnishing of services of the type which, if furnished by a nursing home or certified nursing facility, would constitute skilled care services without complying with nursing home licensure requirements or retaining the services of a licensed nursing home administrator. Such hospital shall include, within its plan of care, assurances for the overall well-being of patients occupying such beds.

F. Nothing herein or set forth in Virginia's rural health care plan shall prohibit any hospital designated as a critical access hospital from leasing the unused portion of its facilities to other health care organizations or reorganizing its corporate structure to facilitate the continuation of the nursing home beds that were licensed to such hospital prior to the designation as a critical access hospital. The health care services delivered by such other health care organizations shall not be construed as part of the critical access hospital's services or license to operate.

G. Any medical care facility licensed as a hospital shall be considered a rural hospital on and after September 30, 2004, pursuant to 42 U.S.C. § 1395ww (d)(8)(E)(ii)(II), if (i) the hospital is located in an area defined as rural by federal statute or regulation; (ii) the Board of Health defines, in regulation, the area in which the hospital is located as a rural health area or the hospital as a rural hospital; or (iii) the hospital was designated, prior to October 1, 2004, as a Medicare-dependent small rural health hospital, as defined in 42 U.S.C. § 1395ww (d)(5)(G)(iv).

1989, cc. 617, 633; 2000, c. 903; 2002, c. 83; 2006, c. 378.

§ 32.1-122.08. Continuation of regulations.

Regulations promulgated by the Virginia Health Planning Board prior to July 1, 2002, concerning health planning and resources development shall remain in force and effect until any such regulation is amended, modified, or repealed by the Board.

1989, cc. 617, 633; 2002, c. 83.

Article 5 - PERINATAL SERVICES

§§ 32.1-122.1 through 32.1-122.4. Repealed.

Repealed by Acts 1992, c. 407.

Article 6 - PRIMARY HEALTH CARE SYSTEM

§ 32.1-122.5. Criteria to identify underserved areas.

The Board of Health shall establish criteria to identify medically underserved areas within the Commonwealth. These criteria shall consist of quantifiable measures sensitive to the unique characteristics of urban and rural jurisdictions which may include the incidence of infant mortality, the availability of primary care resources, poverty levels, and other measures indicating the inadequacy of the primary health care system as determined by the Board. The Board shall also include in these criteria the need for medical care services in the state facilities operated by the Departments of Corrections, Juvenile Justice, and Behavioral Health and Developmental Services.

1990, cc. 874, 877; 2009, cc. 813, 840.

§ 32.1-122.5:1. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish, in addition to the scholarships established pursuant to § 32.1-122.6, annual medical scholarships for students who (i) intend to enter one of the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology and (ii) commit to practicing in a medically underserved area of Southwest Virginia. Such scholarships shall be awarded to students in good standing at the Quillen School of Medicine of East Tennessee State University, with preference being given to bona fide residents of Virginia, as determined by § 23.1-502 and specifically for bona fide residents of Southwest Virginia. The Board of Health shall request the governing board of East Tennessee State University to submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these medical scholarships. The Commissioner shall award the scholarships to applicants whose names are submitted by the governing board.

B. The provisions of § 32.1-122.6 and all regulations of the Board promulgated pursuant to § 32.1-122.6 shall apply to the award of the scholarships established herein and to the applicants for and recipients of such scholarships. In addition to the regulations established pursuant to § 32.1-122.6, the Board shall define Southwest Virginia by designating Planning Districts one, two, and three as those jurisdictions in which eligible students shall be required to serve.

1992, c. 358; 1994, c. 281.

§ 32.1-122.6. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual medical scholarships for students who intend to enter the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology and who are in good

standing at a medical school in the United States that has received accreditation or provisional accreditation from the Liaison Committee on Medical Education or the Bureau of Professional Education of the American Osteopathic Association. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

B. The Board shall promulgate regulations to administer this scholarship program that shall include:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23.1-502, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin medical practice in one of the designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete medical school or who fail to honor the obligation to engage in medical practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Reporting of data related to the recipients of the scholarships by the medical schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to engage continuously in one of the designated specialties of medical practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of medical practice such as military service or public health service may be substituted for the obligation to practice in one of the designated specialties in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for physicians by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area in one of the designated specialties for the requisite number of years.

The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in medical school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice medicine in one of the designated specialties in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area in one of the designated specialties, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of medicine, whichever is later. All such funds, including any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorney fees incurred by the Commonwealth in such collection.

H. For purposes of this section, the term "underserved area" includes those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

1990, cc. 874, 877; 1991, c. 134; 1994, cc. 281, 867; 2000, c. 926; 2001, c. 188; 2002, cc. 87, 478; 2015, c. 532.

§ 32.1-122.6:01. Board of Health to award certain scholarships and loan repayment funds.

A. The Board of Health shall award to eligible part-time and full-time students the nursing scholarships available from the Nursing Scholarship and Loan Repayment Fund established in § 54.1-3011.2 pursuant to the procedures for the administration of the scholarships awarded through § 23.1-614.

Eligible part-time and full-time students shall be bona fide residents of Virginia as determined by § 23.1-502, shall be enrolled in or accepted for enrollment in nursing education programs preparing them for examination for licensure as practical nurses or registered nurses, and shall also meet such other criteria as may be established by the Board of Health. Prior to awarding any scholarship, the Board of Health shall require the recipient to agree to perform a period of nursing service in this Commonwealth for each scholarship. The Board may establish variable periods of service as conditions for receipt of scholarships according to the amounts of the awards. In the event that fees are collected pursuant to § 54.1-3011.1, the Board shall award the scholarships funded through such fees to practical nurses and registered nurses in proportion to the funds generated by the fees for licensure from such nurses.

Eligibility for these scholarships shall be limited to a total of four academic years. The scholarships shall be awarded on a competitive basis, considering the financial needs of the applicant, and all such funds shall be used only for payment of charges for tuition, fees, room, board, or other educational expenses as prescribed by the Board of Health.

The Board of Health shall submit the names of the scholarship recipients to the Board of Nursing, which shall be responsible for transmission of the funds to the appropriate institution to be credited to the account of the recipient.

B. The Board shall establish a nursing scholarship and loan repayment program for registered nurses, licensed practical nurses, and certified nurse aides who agree to perform a period of service in a Commonwealth long-term care facility pursuant to regulations promulgated by the Board in cooperation with the Board of Nursing. The Board shall submit the names of the scholarship and loan repayment recipients to the Board of Nursing, which shall be responsible for transmission of the funds to the appropriate educational or financial institution to be credited to the account of the recipient.

1. The nursing scholarships authorized by this subsection shall be awarded to eligible part-time and full-time students who are bona fide residents of Virginia as determined by § 23.1-502 and who are (a) accepted for enrollment or are enrolled in approved nursing education programs preparing them for examination for licensure as practical nurses or registered nurses or (b) accepted for enrollment or enrolled in approved nurse aide education programs preparing them for certification as authorized in

Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1. Prior to awarding any scholarship, the Board shall require the recipient to agree to perform a period of nursing service in a long-term care facility in the Commonwealth for each scholarship. The Board may establish variable periods of service according to the amount of the award in a long-term care facility as a condition for receipt of a scholarship.

Eligibility for these scholarships shall be limited to a total of four academic years. The scholarships shall be awarded on a competitive basis, considering the financial needs of the applicant, and all such funds shall be used only for payment of charges for tuition, fees, room, board, or other educational expenses as prescribed by the Board.

2. The nursing loan repayment program authorized by this subsection shall be established for registered nurses, licensed practical nurses, and certified nurse aides who: (a) are bona fide residents of Virginia as determined by § 23.1-502, (b) have graduated from an approved educational program pursuant to Chapter 30 (§ 54.1-3000 et seq.) of Title 54.1, and (c) meet such other criteria as determined by the Board. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of nursing service in a long-term care facility in the Commonwealth as a condition for loan repayment according to the amount of the award.

1991, c. 669; 2000, cc. 240, 254; 2002, c. 290.

§ 32.1-122.6:03. Conditional grants for certain physician assistant students.

A. The Board of Health shall establish annual physician assistant scholarships for students who intend to enter an accredited physician assistant program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a physician assistant scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations that shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for awarding the scholarship to ensure that a recipient will fulfill the practice obligations established in this section;

3. Standards to ensure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23.1-502, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a physician assistant in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a physician assistant for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. Prior to promulgating any regulation establishing any preferences noted in subdivision B 4, the Board shall issue written findings stating the bases for its decisions that any such preferences provided by the regulation comply with constitutional principles of equal protection.

D. Until such time as a fully accredited physician assistant education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

E. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

F. Any scholarship amounts repaid by recipients pursuant to subdivision B 6, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

1997, c. 806; 2000, c. 926; 2001, c. 188.

§ 32.1-122.6:04. Nurse Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a tuition loan repayment program for licensed practical nurses, licensed registered nurses, or certified nurse aides who meet criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of nursing service in this Commonwealth.

B. The Board shall promulgate regulations for the implementation and administration of the Nurse Loan Repayment Program. Applications for participation in the program shall be accepted from graduates of nursing education programs that prepare them for examination for licensure as a practical nurse or registered nurse or certification as a certified nurse aide, but preference shall be given to graduates of nursing education programs located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of nursing service in the Commonwealth required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

2001, c. 188; 2021, Sp. Sess. I, c. 238.

§ 32.1-122.6:1. Physician Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish a physician loan repayment program for graduates of accredited medical schools who have a specialty in the primary care areas of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology, or who are currently employed in a geriatrics fellowship, and who meet other criteria as determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of medical service in the Commonwealth in a medically underserved area as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5, or, in the case of graduates of accredited medical schools who are currently employed in a geriatrics fellowship, the Board shall require the recipient to agree to perform, at minimum, a two-year period of medical service in the Commonwealth.

B. The Board shall promulgate regulations for the implementation of the Physician Loan Repayment Program. Applications for participation in the program will be accepted from a graduate of any accredited medical school, but preference will be given to graduates of medical schools located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of medical service in an underserved area or a two-year period as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

1994, c. 111; 2000, c. 926; 2001, c. 188; 2013, c. 255.

§ 32.1-122.6:02. Conditional grants for certain advanced practice registered nursing students.

A. The Board of Health shall establish annual nursing scholarships for students who intend to enter an accredited advanced practice registered nurse program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a nursing scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23.1-502, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as an advanced practice registered nurse in an underserved area of the Commonwealth within two years following completion of training;

6. Designations that students in advanced practice registered nurse specialties, including nurse midwife, receive priority scholarships;

7. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as an advanced practice registered nurse for a period of years equal to the number of annual scholarships received;

8. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

9. Methods for reporting data related to the recipients of the scholarships.

C. Until such time as a fully accredited nurse midwife education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

D. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

E. Any scholarship amounts repaid by recipients pursuant to subdivision B 7, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

1993, cc. 197, 337; 2000, c. 926; 2001, c. 188; 2023, c. 183.

§ 32.1-122.7. Virginia Health Workforce Development Authority; purpose.

A. There is hereby created as a public body corporate and as a political subdivision of the Commonwealth the Virginia Health Workforce Development Authority (the Authority), with such public and corporate powers as are set forth in § 32.1-122.7:2. The Authority is hereby constituted as a public instrumentality, exercising public and essential governmental functions with the power and purpose to provide for the health, welfare, convenience, knowledge, benefit, and prosperity of the residents of the Commonwealth and such other persons who might be served by the Authority. The Authority is established to move the Commonwealth forward in achieving its vision of ensuring a quality health workforce for all Virginians.

B. The mission of the Authority is to facilitate the development of a statewide health professions pipeline that identifies, educates, recruits, and retains a diverse, appropriately geographically distributed, and culturally competent quality workforce. The mission of the Authority is accomplished by: (i) providing the statewide infrastructure required for health workforce needs assessment and planning that maintains engagement by health professions training programs in decision making and program implementation; (ii) serving as the advisory board and setting priorities for the Virginia Area Health Education Centers Program; (iii) coordinating with and serving as a resource to relevant state, regional, and local entities, including the Department of Health Professions Workforce Data Center,

the Joint Legislative Audit and Review Commission, the Joint Commission on Health Care, the Southwest Virginia Health Authority, or any similar regional health authority that may be developed; (iv) informing state and local policy development as it pertains to health care delivery, training, and education; (v) identifying and promoting evidence-based strategies for health workforce pipeline development and interdisciplinary health care service models, particularly those affecting rural and other underserved areas; (vi) supporting communities in their health workforce recruitment and retention efforts and developing partnerships and promoting models of participatory engagement with business and community-based and social organizations to foster integration of health care training and education; (vii) advocating for programs that will result in reducing the debt load of newly trained health professionals; (viii) identifying high priority target areas within each region of the Commonwealth and working toward health workforce development initiatives that improve health measurably in those areas; (ix) fostering or creating innovative health workforce development models that provide both health and economic benefits to the regions they serve; (x) developing strategies to increase diversity in the health workforce by examining demographic data on race and ethnicity in training programs and health professional licensure; (xi) identifying ways to leverage technology to increase access to health workforce training and health care delivery; and (xii) developing a centralized health care careers roadmap in partnership with the Department of Health Professions that includes information on both licensed and unlicensed professions and that is disseminated to the Commonwealth's health care workforce stakeholders to raise awareness about available career pathways.

1990, cc. 874, 877; 1997, c. 329; 2000, c. 480; 2010, cc. 187, 488; 2021, Sp. Sess. I, c. 264.

§ 32.1-122.7:1. Board of Directors of the Virginia Health Workforce Development Authority.

The Virginia Health Workforce Development Authority shall be governed by a Board of Directors. The Board of Directors shall have a total membership of 15 members that shall consist of three legislative members, nine nonlegislative citizen members, and three ex officio members. Members shall be appointed as follows: two members of the House of Delegates, to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; one member of the Senate, to be appointed by the Senate Committee on Rules; and nine nonlegislative citizen members, three of whom shall be representatives of health professional educational or training programs, five of whom shall be health professionals or employers or representatives of health professionals, and one of whom shall be a representative of community health, to be appointed by the Governor. The Commissioner of Health or his designee, the Chancellor of the Virginia Community College System or his designee, and the Director of the Department of Health Professions or his designee shall serve ex officio with voting privileges. Members appointed by the Governor shall be citizens of the Commonwealth.

Legislative members and ex officio members shall serve terms coincident with their terms of office. All appointments of nonlegislative citizen members shall be for two-year terms following the initial staggering of terms. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Legislative and citizen members may be reappointed; however, no citizen member shall

serve more than four consecutive two-year terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's term limit. Vacancies shall be filled in the same manner as the original appointments.

The Board of Directors shall elect a chairman and vice-chairman annually from among its members. A majority of the members of the Board of Directors shall constitute a quorum.

The Board of Directors shall report biennially on the activities and recommendations of the Authority to the Secretary of Health and Human Resources, the Secretary of Education, the Secretary of Commerce and Trade, the Chief Workforce Development Advisor, the State Board of Health, the State Council of Higher Education for Virginia, the Joint Commission on Health Care, the Governor, and the General Assembly. In any reporting period where state general funds are appropriated to the Authority, the report shall include a detailed summary of how state general funds were expended.

The accounts and records of the Authority showing the receipt and disbursement of funds from whatever source derived shall be in a form prescribed by the Auditor of Public Accounts. The Auditor of Public Accounts, or his legally authorized representative, shall examine the accounts of the Authority as determined necessary by the Auditor of Public Accounts. The cost of such audit shall be borne by the Authority.

2010, cc. 187, 488; 2014, c. 720; 2018, cc. 57, 307; 2021, Sp. Sess. I, c. 264.

§ 32.1-122.7:2. Powers and duties of the Virginia Health Workforce Development Authority; exemptions.

A. The Authority is authorized to serve as the incorporated consortium of allopathic and osteopathic medical schools in Virginia as required by federal statute to qualify for the receipt of Area Health Education Centers programs, legislatively mandated under the Public Health Service Act as amended, Title VII, Section 751, and 42 U.S.C. § 294a, and to administer federal, state, and local programs as needed to carry out its public purpose and objectives. The Authority is further authorized to exercise independently the powers conferred by this section in furtherance of its corporate and public purposes to benefit citizens and such other persons who might be served by the Authority.

B. The Authority is authorized to monitor, collect, and track data pertaining to health care delivery, training, and education from Virginia educational institutions and other entities as needed to carry out its public purpose and objectives in areas where such data efforts do not already exist.

C. The Authority shall have the authority to assess policies, engage in policy development, and make policy recommendations.

D. The Authority shall have the authority to apply for and accept federal, state, and local public and private grants, loans, appropriations, and donations; hire and compensate staff, including an executive director; rent, lease, buy, own, acquire, and dispose of property, real or personal; participate in joint ventures, including to make contracts and other agreements with public and private entities in order to

carry out its public purpose and objectives; and make bylaws for the management and regulation of its affairs.

E. The Authority shall be exempt from the provisions of Chapters 29 (§ 2.2-2900 et seq.) and 43 (§ 2.2-4300 et seq.) of Title 2.2.

F. The exercise of powers granted by this article and the undertaking of activities in the furtherance of the purpose of the Authority shall constitute the performance of essential governmental functions. Therefore, the Authority shall be exempt from any tax or assessment upon any project or property acquired or used by the Authority under the provisions of this article or upon the income therefrom, including sales and use taxes on tangible personal property used in the operation of the Authority. This exemption shall not extend to persons conducting business for which local or state taxes would otherwise be required.

2010, cc. 187, 488.

§ 32.1-122.8. Board's authority to receive and expend funds.

The Board of Health is hereby authorized to apply for, receive, and expend federal and any other available funds for the enhancement of the primary health care system including, but not limited to, any funds designated for any physician loan repayment program, medical scholarships, and area health education centers.

1990, cc. 874, 877.

§ 32.1-122.9. Conditional grants for certain dental students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual dental scholarships for students in good standing at Virginia Commonwealth University. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing board of Virginia Commonwealth University shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these dental scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing board.

B. The Board, after consultation with the School of Dentistry of Virginia Commonwealth University, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that recipients participate in the Commonwealth's medical assistance services program, established pursuant to § 32.1-325, and the Family Access to Medical Insurance Security

Plan, established pursuant to § 32.1-351, and that recipients do not limit the number of persons enrolled in these programs who are admitted to their dental practice;

4. Assurances that bona fide residents of Virginia, as determined by § 23.1-502, students of economically disadvantaged backgrounds and residents of underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin dental practice in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete dental school or who fail to honor the obligation to engage in dental practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Reporting of data related to the recipients of the scholarships by the dental schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the dental course of Virginia Commonwealth University until his graduation and, upon graduation or upon completing a term not to exceed four years as an intern or resident at an approved institution or facility, to promptly begin and thereafter engage continuously in dental practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of dental practice such as military service or public health service may be substituted for the obligation to practice in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for dentists by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in dental school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of dentistry, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such

amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice dentistry in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of dentistry, whichever is later. All such funds, including any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

H. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

1994, c. 867; 2000, c. 926; 2001, c. 188; 2002, c. 52.

§ 32.1-122.9:1. Dentist Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of dental service in this Commonwealth in an underserved area as defined in § 32.1-122.5 or a dental health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5. The Board also shall ensure that recipients (i) participate in the Commonwealth's medical assistance services program established pursuant to § 32.1-325 and the Family Access to Medical Insurance Security Plan established pursuant to § 32.1-351, and (ii) do not limit the number of persons enrolled in these programs who are admitted to their dental practice.

B. Applications for participation in the program will be accepted from a graduate of any accredited dental school, but preference will be given to graduates of Virginia Commonwealth University's School of Dentistry.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of dental service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

2000, cc. 174, 202; 2001, c. 188; 2002, c. 52.

§ 32.1-122.10. Conditional grants for certain dental hygiene students.

A. The Board of Health shall establish annual dental hygiene scholarships for students who intend to enter an accredited dental hygiene program in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to dental hygiene care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23.1-502, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a dental hygienist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a dental hygienist for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

D. Any scholarship amounts repaid by recipients pursuant to subdivision B 6, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

1994, c. 867; 2000, c. 926; 2001, c. 188.

Article 6.1 - LOCAL HEALTH PARTNERSHIP AUTHORITIES

§ 32.1-122.10:001. Purpose; one or more localities may create authority; advertisement and notice of hearing.

A. Communities lack the ability to coordinate, across jurisdictions, health partnership efforts between local governments and private providers of health care services, which leads to duplicative and inefficient services. Such public/private partnerships could (i) encourage the use of service delivery that otherwise might have required government funding or programs; (ii) allow governments to fully participate in such partnerships; (iii) maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs; (iv) allow innovative funding mechanisms to leverage public funds; (v) allow appropriate information sharing to ensure the adequacy and quality of services delivered; (vi) provide liability protection for volunteers providing services under programs sponsored or approved by the authority; (vii) provide a mechanism to ensure that services provided in the community are necessary, appropriate, and provided by trained and supervised persons; and (viii) allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.

B. The governing body of a locality may by ordinance or resolution, or the governing bodies of two or more localities may by concurrent ordinances or resolutions or by agreement, create a local health partnership authority which shall have as its purpose developing partnerships between public and private providers. The ordinance, resolution or agreement creating the authority shall not be adopted or approved until a public hearing has been held on the question of its adoption or approval. The authority shall be a public body politic and corporate.

C. The governing body of each participating locality shall cause to be advertised at least one time in a newspaper of general circulation in such locality a copy of the ordinance, resolution or agreement creating the authority, or a descriptive summary of the ordinance, resolution or agreement and a reference to the place where a copy of such ordinance, resolution or agreement can be obtained, and notice of the day, not less than 30 days after publication of the advertisement, on which a public hearing will be held on the ordinance, resolution or agreement.

D. No authority created pursuant to this article shall be exempt from any of the provisions of the Certificate of Public Need laws and regulations of the Commonwealth.

E. No authority created pursuant to this article shall be allowed to issue bonds or other form of indebtedness.

F. Any authority created pursuant to this article shall report on programmatic initiatives on an annual basis to the Joint Commission on Health Care.

2001, c. 671; 2003, cc. 63, 70.

§ 32.1-122.10:002. Board of directors; expenses; officers; terms of office; quorum; annual report.

A. All powers, rights and duties conferred by this article, or other provisions of law, upon an authority shall be exercised by a board of directors. The participating localities in the local health partnership authority shall determine the composition of the membership of the board. At a minimum, the board shall be composed of one locally elected official, one representative of the health care industry, one representative of the business community, and one representative of the nongovernmental human services agencies from each participating locality if such nongovernmental human services agencies exist; and, sufficient citizen members to constitute the majority of the board, who shall not be employed by, nor board members of, nor financially linked to the partnering agencies, groups and corporations involved.

B. Each member of a board shall serve for a term of four years and may serve no more than two consecutive full terms. The creation of a vacancy on the board shall be filled in the same manner by the appointing locality, such position being filled for the unexpired term.

C. Members of the board of directors shall be reimbursed for actual expenses incurred in the performance of their duties from funds available to the board and according to policy determined by the board.

D. Each board shall elect from its membership a chairman, vice-chairman and secretary/treasurer. The board shall appoint an executive director who shall discharge such functions as may be directed by the board. The authority shall employ such staff as may be appropriate to coordinate the work of the participating organizations in support of programs and services approved by each board. The executive director and staff shall be paid from funds received by the authority.

E. Each board, promptly following the close of the fiscal year, shall submit an annual report of the authority's activities of the preceding year to the governing body of each member locality and to the Joint Commission on Health Care. Each such report shall set forth a complete operating and financial statement covering the operation of the authority during such year.

2001, c. 671; 2003, cc. 63, 70.

§ 32.1-122.10:003. Office of the authority.

The board of each authority shall establish a principal office within one of the participating jurisdictions. The title to all property of every kind belonging to the authority shall be titled to the authority for the benefit of all of its members.

2001, c. 671.

§ 32.1-122.10:004. Powers of the authority.

Any authority shall have the following powers:

1. Each authority is vested with the powers of a body corporate, including the power to sue and be sued in its own name, to adopt and use a common seal and to alter the same as may be deemed expedient, to make and execute contracts and other instruments necessary or convenient to the exercise of the powers of the authority, and to make, amend or repeal bylaws, rules and regulations, not inconsistent with law, to carry into effect the powers and purposes of the authority.

2. To foster and stimulate the cooperative assessment and provision of health care in the community by local governments, private entities and volunteers.

3. To cooperate with local and state health care planning entities, and local, state or federal governments in the discharge of its duties.

4. To solicit and accept grants or donations from local, state or federal governments or any instrumentality thereof, private entities, or any other source, public or private, for or in aid of any project of the authority to provide health services as defined in subsection A of § 32.1-122.10:001.

5. To do any and all other acts and things that may be reasonably necessary and convenient to carry out its purposes and powers.

2001, c. 671.

§ 32.1-122.10:005. Licensed agents; liability.

No volunteer of any participating entity who is duly licensed to provide health care services shall be liable for any civil damages for any act or omission resulting from the rendering of such services to a recipient of a program designated by the authority when such services are provided without charge and within the scope of the volunteer's authority to practice and the volunteer delivering such services has no legal or financial interest in the program to which the patient is referred, unless such act or omission was the result of gross negligence or willful misconduct. The provisions of this section shall apply only to noninvasive and minimally invasive procedures limited to finger sticks and injections performed as part of health care services. The provisions of this subsection shall apply to those appropriate volunteers providing care during the time in which such care is rendered free of charge.

2001, c. 671.

Article 7 - REVIEW OF HEALTH SERVICES QUALITY

§ 32.1-122.10:01. Expired.

Expired.

Article 8 - HEALTH WORKFORCE RECRUITMENT AND RETENTION

§ 32.1-122.20. Recruitment and retention of health care providers.

The Commissioner shall direct the Commonwealth's activities and programs for recruiting and retaining health care providers for underserved populations, underserved areas, and health professional shortage areas (HPSAs) designated throughout the Commonwealth. The duties and responsibilities of the Commissioner shall include, but not be limited to:

1. Designating and updating as necessary the designation of underserved areas that meet the criteria established by the Board pursuant to § 32.1-122.5;

2. Designating and updating as necessary those areas of the state which meet the criteria of dental, primary care and mental health professional shortage areas as provided in 42 C.F.R. Part 5;

3. Administering the scholarship and loan repayment programs pursuant to Article 6 (§ 32.1-122.5 et seq.) of this chapter as well as any other programs or activities authorized in the appropriation act for recruiting and retaining providers for the Commonwealth's underserved populations, underserved areas and HPSAs;

4. Recruiting health care providers, residents, and students in Virginia and other states to care for Virginia's underserved populations and practice in underserved areas and HPSAs throughout the Commonwealth;

5. Publicizing the functions, programs, and activities of the Department available to assist providers in establishing a practice in underserved areas and HPSAs throughout the Commonwealth;

6. Coordinating the Department's health workforce activities with other state agencies as well as public and private entities in Virginia involved in health workforce training, recruitment, and retention; and

7. Identifying and recommending to the Governor and the General Assembly new programs, activities, and strategies for increasing the number of providers practicing in Virginia's underserved areas and HPSAs and serving Virginia's underserved populations.

2000, cc. 175, 200; 2011, c. 37.

§ 32.1-122.21. Repealed.

Repealed by Acts 2010, cc. 187 and 488, cl. 2. See note for effective date.

§ 32.1-122.22. Repealed.

Repealed by Acts 2011, c. 37, cl. 2, effective July 1, 2011.

Chapter 5 - REGULATION OF MEDICAL CARE FACILITIES AND SERVICES

Article 1 - HOSPITAL AND NURSING HOME LICENSURE AND INSPECTION

§ 32.1-123. Definitions.

As used in this article unless a different meaning or construction is clearly required by the context or otherwise:

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both, pursuant to § 32.1-137.

"Children's hospital" means a hospital (i) whose inpatients are predominantly under 18 years of age and (ii) which is excluded from the Medicare prospective payment system pursuant to the Social Security Act.

"Class I violation" means failure of a nursing home or certified nursing facility to comply with one or more requirements of state or federal law or regulations which creates a situation that presents an immediate and serious threat to patient health or safety.

"Class II violation" means a pattern of noncompliance by a nursing home or certified nursing facility with one or more federal conditions of participation which indicates delivery of substandard quality of care but does not necessarily create an immediate and serious threat to patient health and safety. Regardless of whether the facility participates in Medicare or Medicaid, the federal conditions of participation shall be the standards for Class II violations.

"Hospital" means any facility licensed pursuant to this article in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as children's hospitals, sanatoriums, sanitariums and general, acute, rehabilitation, chronic disease, short-term, long-term, outpatient surgical, and inpatient or outpatient maternity hospitals.

"Immediate and serious threat" means a situation or condition having a high probability that serious harm or injury to patients could occur at any time, or already has occurred, and may occur again, if patients are not protected effectively from the harm, or the threat is not removed.

"Inspection" means all surveys, inspections, investigations and other procedures necessary for the Department of Health to perform in order to carry out various obligations imposed on the Board or Commissioner by applicable state and federal laws and regulations.

"Nursing home" means any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.

"Nonrelated" means not related by blood or marriage, ascending or descending or first degree full or half collateral.

"Substandard quality of care" means deficiencies in practices of patient care, preservation of patient rights, environmental sanitation, physical plant maintenance, or life safety which, if not corrected, will have a significant harmful effect on patient health and safety.

Code 1950, § 32-298; 1964, c. 54; 1973, c. 477; 1979, c. 711; 1989, c. 618; 2011, c. 433.

§ 32.1-124. Exemptions.

The provisions of §§ 32.1-123 through 32.1-136 shall not be applicable to: (i) a dispensary or first-aid facility maintained by any commercial or industrial plant, educational institution or convent; (ii) an institution licensed by the Department of Behavioral Health and Developmental Services; (iii) an institution or portion thereof licensed by the State Board of Social Services; (iv) a hospital or nursing home owned or operated by an agency of the United States government; (v) an office of one or more physicians or surgeons unless such office is used principally for performing surgery; and (vi) a hospital or nursing home, as defined in § 32.1-123, owned or operated by an agency of the Commonwealth unless such hospital or nursing home or portion thereof is certified as a nursing facility pursuant to § 32.1-137.

Code 1950, § 32-298; 1964, c. 54; 1973, c. 477; 1979, c. 711; 1989, c. 618; 2009, cc. 813, 840.

§ 32.1-125. Establishment or operation of hospitals and nursing homes prohibited without license or certification; licenses not transferable.

A. No person shall own, establish, conduct, maintain, manage or operate in this Commonwealth any hospital or nursing home unless such hospital or nursing home is licensed or certified as provided in this article.

B. No license issued hereunder shall be assignable or transferable.

Code 1950, § 32-299; 1979, c. 711; 1989, c. 618.

§ 32.1-125.01. Failing to report; penalty.

Any hospital or nursing home that has not paid civil penalties assessed for failing to report pursuant to § 54.1-2400.6 shall not be issued a license or certification or a renewal of such.

2003, cc. 753, 762; 2004, c. 64.

§ 32.1-125.1. Inspection of hospitals by state agencies generally.

As used in this section unless the context requires a different meaning, "hospital" means a hospital as defined in § 32.1-123 or 37.2-100.

State agencies shall make or cause to be made only such inspections of hospitals as are necessary to carry out the various obligations imposed on each agency by applicable state and federal laws and regulations. Any on-site inspection by a state agency or a division or unit thereof that substantially complies with the inspection requirements of any other state agency or any other division or unit of the inspecting agency charged with making similar inspections shall be accepted as an equivalent inspection in lieu of an on-site inspection by said agency or by a division or unit of the inspecting agency. A state agency shall coordinate its hospital inspections both internally and with those required by other state agencies so as to ensure that the requirements of this section are met. No hospital shall receive additional inspections until all other licensed hospitals in the Commonwealth have also been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations, (ii) required by a uniformly applied risk-based schedule established by the Department, (iii) necessary to investigate a complaint regarding the hospital, or (iv) otherwise deemed necessary by the Commissioner or his designee to protect the health and safety of the public.

Notwithstanding any provision of law to the contrary, all hospitals licensed by the Department of Health or Department of Behavioral Health and Developmental Services that have been certified under the provisions of Title XVIII of the Social Security Act for hospital or psychiatric services or that have obtained accreditation from a national accrediting organization granted authority by the Centers for Medicare and Medicaid Services to ensure compliance with Medicare conditions of participation pursuant to § 1865 of Title XVIII of the Social Security Act (42 U.S.C. § 1395bb) may be subject to inspections so long as such certification or accreditation is maintained but only to the extent necessary to ensure the public health and safety.

Code 1950, § 32-300.1; 1979, c. 220; 1989, c. 618; 2009, cc. 813, 840; 2014, c. 320; 2017, c. 465.

§ 32.1-125.2. Disclosure of other providers of services.

A. 1. Any hospital which has, or is affiliated with or under the common control of a holding company that has, a financial interest in a facility or entity that engages in the provision of health-related outpatient services, appliances or devices of which a patient is in need, or any employee or volunteer associated with such hospital, shall, prior to referring the patient to such type of a facility or entity, provide the patient or his representative with a notice stating in bold print that the services, appliances or devices may be available from other suppliers in the community.

2. As used in this section, "representative" means any member of the immediate family of the patient or any other person acting on his behalf and who is not a health care provider or other person who may profit from such referral.

B. The Attorney General, an attorney for the Commonwealth, the attorney for a city, county or town or any aggrieved patient may cause an action to be brought in the appropriate circuit court in the name of the Commonwealth, of the county, city or town, or of any aggrieved patient, to enjoin any violation of this section. The circuit court having jurisdiction may enjoin such violations, notwithstanding the existence of an adequate remedy at law. When an injunction is issued, the circuit court shall impose a civil fine to be paid to the Literary Fund not to exceed $1,000. In any action under this section, it shall not be necessary that damages be proved.

1988, c. 252.

§ 32.1-125.3. Bed capacity and licensure in hospitals designated as critical access hospitals; designation as rural hospital.

A. Any medical care facility licensed as a hospital pursuant to this article that (i) has been certified, as provided in § 32.1-122.07, as a critical access hospital by the Commissioner of Health in compliance with the certification regulations promulgated by the Health Care Financing Administration pursuant to Title XVIII of the Social Security Act, as amended, and (ii) has, as a result of the critical access certification, been required to reduce its licensed bed capacity to conform to the critical access certification requirement shall, upon termination of its critical access hospital certification, be licensed to operate at the licensed bed capacity in existence prior to the critical access hospital certification

without being required to apply for and obtain a certificate of public need for such bed capacity in accordance with Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title.

B. Any medical care facility licensed as a hospital shall be considered a rural hospital on and after September 30, 2004, pursuant to 42 U.S.C. § 1395ww (d)(8)(E)(ii)(II), if (i) the hospital is located in an area defined as rural by federal statute or regulation; (ii) the Board of Health defines, in regulation, the area in which the hospital is located as a rural health area or the hospital as a rural hospital; or (iii) the hospital was designated, prior to October 1, 2004, as a Medicare-dependent small rural health hospital, as defined in 42 U.S.C. § 1395ww (d)(5)(G)(iv).

2001, c. 579; 2006, c. 378.

§ 32.1-125.4. Retaliation or discrimination against complainants.

No hospital may retaliate or discriminate in any manner against any person who (i) in good faith complains or provides information to, or otherwise cooperates with, the Department or any other agency of government or any person or entity operating under contract with an agency of government having responsibility for protecting the rights of patients of hospitals, or (ii) attempts to assert any right protected by state or federal law.

2003, c. 309.

§ 32.1-125.5. Confidentiality of complainant's identity.

Whenever the Department conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the Department, in its discretion, from disclosing to the hospital the nature of the complaint or the identity of the patient who is the subject of the complaint. Nothing contained herein shall prevent the Department or its employees from making reports under § 63.2-1509 or Article 2 (§ 63.2-1603 et seq.) of Chapter 16 of Title 63.2. If the Department intends to rely, in whole or in part, on any statements made by the complainant, at any administrative hearing brought against the hospital, the Department shall disclose the identity of the complainant to the hospital in a reasonable time in advance of such hearing.

2003, c. 309.

§ 32.1-126. Commissioner to inspect and to issue licenses to or assure compliance with certification requirements for hospitals, nursing homes, and certified nursing facilities; notice of denial of license; consultative advice and assistance; notice to electric utilities.

A. Pursuant to this article, the Commissioner shall issue licenses to, and assure compliance with certification requirements for hospitals and nursing homes, and assure compliance with certification requirements for facilities owned or operated by agencies of the Commonwealth as defined in subdivision (vi) of § 32.1-124, which after inspection are found to be in compliance with the provisions of this article and with all applicable state and federal regulations. The Commissioner shall notify by certified mail or by overnight express mail any applicant denied a license of the reasons for such denial.

B. The Commissioner shall cause each and every hospital, nursing home, and certified nursing facility to be inspected periodically, but not less often than biennially, in accordance with the provisions of this article and regulations of the Board. However, except when performed in conjunction with an inspection required by the Centers for Medicare and Medicaid Services, no hospital, nursing home, or certified nursing facility shall receive additional inspections until all other hospitals, nursing homes, or certified nursing facilities in the Commonwealth, respectively, have also been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations; (ii) required by a uniformly applied risk-based schedule established by the Department; (iii) necessary to investigate a complaint regarding the hospital, nursing home, or certified nursing facility; or (iv) otherwise deemed necessary by the Commissioner or his designee to protect the health and safety of the public.

Unless expressly prohibited by federal statute or regulation, the findings of the Commissioner, with respect to periodic surveys of nursing facilities conducted pursuant to the Survey, Certification, and Enforcement Procedures set forth in 42 C.F.R. Part 488, shall be considered case decisions pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) and shall be subject to the Department's informal dispute resolution procedures, or, at the option of the Department or the nursing facility, the formal fact-finding procedures under § 2.2-4020. The Commonwealth shall be deemed the proponent for purposes of § 2.2-4020. Further, notwithstanding the provisions of clause (iii) of subsection A of § 2.2-4025, such case decisions shall also be subject to the right to court review pursuant to Article 5 (§ 2.2-4025 et seq.) of Chapter 40 of Title 2.2.

C. The Commissioner may, in accordance with regulations of the Board, provide for consultative advice and assistance, with such limitations and restrictions as he deems proper, to any person who intends to apply for a hospital or nursing home license or nursing facility certification.

D. For the purpose of facilitating the prompt restoration of electrical service and prioritization of customers during widespread power outages, the Commissioner shall notify on a quarterly basis all electric utilities serving customers in Virginia as to the location of all nursing homes licensed in the Commonwealth. The requirements of this subsection shall be met if the Commissioner maintains such information on an electronic database accessible by electric utilities serving customers in Virginia.

E. No person shall use, in any advertisement for professional services provided by such person, the results of any survey, inspection, or investigation of a nursing home or certified nursing facility conducted by a state or federal agency, including any statement of deficiencies, finding of deficiencies, or plan of corrective action, unless the advertisement includes all of the following:

1. The date on which the survey, inspection, or investigation was conducted;

2. A statement that the nursing home or certified nursing facility is required to submit a plan of correction in response to every statement of deficiency;

3. If a finding or deficiency cited in a statement of deficiencies has been corrected, a statement that the finding or deficiency has been corrected and the date on which the finding or deficiency was corrected; and

4. A statement that the advertisement is not authorized or endorsed by the Virginia Department of Health, the Centers for Medicare and Medicaid Services, the Office of the Inspector General, or any other governmental agency.

The information required by this subsection shall be in the same color, font, and size as all other language on or in the advertisement and shall appear as prominently as all other language used in the advertisement. Nothing in this subsection shall be construed to prohibit the results of a survey, inspection, or investigation from being used in any administrative proceeding, civil proceeding, or criminal investigation or prosecution, in accordance with the rules set forth by the applicable tribunal.

Code 1950, §§ 32-300, 32-305; 1977, c. 155; 1979, c. 711; 1989, c. 618; 1996, cc. 940, 999; 2000, c. 967; 2002, c. 514; 2004, c. 304; 2017, c. 465; 2018, c. 453; 2019, cc. 291, 292.

§ 32.1-126.01. Employment for compensation of persons convicted of barrier crimes prohibited; criminal records check required; suspension or revocation of license.

A. A licensed nursing home shall not hire for compensated employment persons who have been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02. However, a licensed nursing home may hire an applicant who has been convicted of one such offense punishable as a misdemeanor that does not involve abuse or neglect if five years have elapsed following the conviction.

Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth. Any person making a materially false statement when providing such sworn statement or affirmation regarding any such offense is guilty upon conviction of a Class 1 misdemeanor. Further dissemination of the information provided pursuant to this section is prohibited other than to a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record clearance or original criminal history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of this section. The provisions of this section shall be enforced by the Commissioner. If an applicant is denied employment because of convictions appearing on his criminal history record, the nursing home shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant.

The provisions of this section shall not apply to volunteers who work with the permission or under the supervision of a person who has received a clearance pursuant to this section.

B. A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct.

C. A licensed nursing home shall notify and provide to all students a copy of the provisions of this section prior to or upon enrollment in a certified nurse aide program operated by such nursing home.

1992, c. 844; 1993, cc. 17, 657; 1999, c. 637; 2001, c. 329; 2003, c. 517; 2006, cc. 701, 764; 2012, c. 383; 2014, c. 129; 2017, c. 809.

§ 32.1-126.02. Hospital pharmacy employees; criminal records check required.

A. A licensed hospital shall obtain, within sixty days of employment of any compensated employee of the hospital whose duties will provide access to controlled substances as defined in § 54.1-3401 within the hospital pharmacy, who is not licensed by the Board of Pharmacy, an original criminal history record information from the Central Criminal Records Exchange. The cost of obtaining the criminal history record information shall be borne by the hospital.

Any person applying to work in a hospital whose duties will provide access to controlled substances as defined in § 54.1-3401 within the hospital pharmacy, who is not licensed by the Board of Pharmacy, shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or without the Commonwealth. Any person making a materially false statement when providing such sworn statement or affirmation shall be guilty upon conviction of a Class 1 misdemeanor. Further dissemination of the information provided pursuant to this section is prohibited other than to a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

The provisions of this section shall be enforced by the Commissioner. If an individual is denied or terminated from employment because of convictions appearing on his criminal history record, the hospital shall provide, upon the written request of the individual, a copy of the information obtained from the Central Criminal Records Exchange to the individual.

B. A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct.

1996, c. 428.

§ 32.1-126.1. Asbestos inspection for hospitals.

The Commissioner shall not issue a license to or renew the license of any hospital which is located in a building built prior to 1978 until he receives a written statement that either (i) the hospital has been inspected for asbestos in accordance with standards in effect at the time of inspection; or (ii) that asbestos inspection will be conducted within twelve months of issuance or renewal, in accordance

with the standards established pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all other buildings; and (iii) that response actions have been or will be undertaken in accordance with applicable standards. Any asbestos management program or response action undertaken by a hospital shall comply with the standards promulgated pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all others.

The Commissioner may amend the standards for inspections, management programs and response actions for hospitals subject to this section, in accordance with the requirements of the Virginia Administrative Process Act (§ 2.2-4000 et seq.).

The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures made by hospitals pursuant to the provisions of this section.

1987, c. 654; 1988, c. 723; 1989, c. 398; 1993, c. 660.

§ 32.1-126.2. Fire suppression systems required in nursing facilities and nursing homes.

After January 1, 1993, the Commissioner shall not issue a license to or renew the license of any nursing facility or nursing home, regardless of when such institution was constructed, unless the nursing facility or nursing home is equipped with a fire suppression system which complies with the regulations of the Board of Housing and Community Development.

Units consisting of certified long-term care beds described in this section and § 36-99.9 located on the ground floor of general hospitals shall be exempt from the requirements of this section.

1990, c. 804.

§ 32.1-126.3. Fire suppression systems required in hospitals.

After January 1, 1998, the Commissioner shall not issue a license to or renew the license of any hospital, regardless of when such facility was constructed, unless the hospital is equipped with an automatic sprinkler system which complies with the regulations of the Board of Housing and Community Development.

The Commissioner may, at his discretion, extend the time for compliance with this section for any hospital that can demonstrate (i) its inability to comply, if such hospital submits, prior to January 1, 1998, a plan for compliance by a date certain which shall be no later than July 1, 1998, or (ii) that construction is underway for a new facility to house the services currently located in the noncomplying facility and that such construction will be completed and the noncomplying facility relocated by December 31, 1998.

The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures required solely for compliance with this section.

For the purposes of this section and § 36-99.9:1, "automatic sprinkler system" means a device for suppressing fire in patient rooms and other areas of the hospital customarily used for patient care.

1995, c. 631; 1997, c. 552.

§ 32.1-126.4. Hospital standing orders or protocols for certain vaccinations.

A. A hospital may provide or arrange for the administration under a standing order or protocol approved by a member or committee of the hospital's medical staff of (i) influenza vaccinations and (ii) pneumococcal vaccinations, thus waiving the requirement for specific written physician orders for influenza and pneumococcal immunizations. However, no such standing order or protocol shall supersede a physician's authority to issue specific written orders relating to immunizations.

B. Any standing order or protocol authorized by this section shall require that the vaccinations be administered in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention after (i) ascertaining that the vaccination is not medically contraindicated for the patient, (ii) determining the patient's wishes and any religious objections, and (iii) obtaining informed consent from the patient or his legal representative.

C. Vaccinations administered under a standing order or protocol shall be documented in the patient's health record.

2006, c. 432.

§ 32.1-126.5. Consolidation of inspections.

The Commissioner shall identify any inspection of a medical care facility required by this title, Board regulations, the Commissioner, the Department, or any other state regulatory boards or agencies and shall, in collaboration with any such inspecting entity, work to consolidate, as much as practicable, all such inspections in order to minimize the interruption of the provision of care in such medical care facilities.

2019, c. 95.

§ 32.1-127. (Effective until January 1, 2024) Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be

limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for

such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a

security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department, including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency

order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with subsection B of § 54.1-3408.3 and has registered with the Board of Pharmacy;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or

video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility; and

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

Code 1950, § 32-301; 1972, c. 36; 1979, c. 711; 1985, c. 335; 1986, c. 135; 1987, c. 224; 1988, cc. 325, 418; 1989, cc. 434, 618, 699; 1992, cc. 334, 428; 1993, c. 335; 1996, cc. 361, 411; 1997, c. 454; 1998, c. 450; 2000, cc. 176, 810; 2001, c. 463; 2004, c. 762; 2007, cc. 119, 164, 516; 2011, cc. 406, 412, 670; 2013, c. 320; 2014, c. 320; 2015, c. 661; 2016, c. 85; 2017, cc. 175, 462; 2018, cc. 271, 368, 454, 565, 682, 791; 2019, cc. 136, 343; 2020, cc. 714, 829, 846, 898, 899, 900, 942; 2020, Sp. Sess. I, cc. 10, 11; 2021, Sp. Sess. I, cc. 219, 233, 525; 2022, cc. 218, 712, 772; 2023, c. 417.

§ 32.1-127. (Effective January 1, 2024, until July 1, 2025) Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be

limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for

such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a

security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department, including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency

order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with § 4.1-1601;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this

subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility; and

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

Code 1950, § 32-301; 1972, c. 36; 1979, c. 711; 1985, c. 335; 1986, c. 135; 1987, c. 224; 1988, cc. 325, 418; 1989, cc. 434, 618, 699; 1992, cc. 334, 428; 1993, c. 335; 1996, cc. 361, 411; 1997, c. 454; 1998, c. 450; 2000, cc. 176, 810; 2001, c. 463; 2004, c. 762; 2007, cc. 119, 164, 516; 2011, cc. 406, 412, 670; 2013, c. 320; 2014, c. 320; 2015, c. 661; 2016, c. 85; 2017, cc. 175, 462; 2018, cc. 271, 368, 454, 565, 682, 791; 2019, cc. 136, 343; 2020, cc. 714, 829, 846, 898, 899, 900, 942; 2020, Sp. Sess. I, cc. 10, 11; 2021, Sp. Sess. I, cc. 219, 233, 525; 2022, cc. 218, 712, 772; 2023, cc. 417, 740, 773.

§ 32.1-127. (Effective July 1, 2025) Regulations.

A. The regulations promulgated by the Board to carry out the provisions of this article shall be in substantial conformity to the standards of health, hygiene, sanitation, construction and safety as established and recognized by medical and health care professionals and by specialists in matters of public health and safety, including health and safety standards established under provisions of Title XVIII and Title XIX of the Social Security Act, and to the provisions of Article 2 (§ 32.1-138 et seq.).

B. Such regulations:

1. Shall include minimum standards for (i) the construction and maintenance of hospitals, nursing homes and certified nursing facilities to ensure the environmental protection and the life safety of its patients, employees, and the public; (ii) the operation, staffing and equipping of hospitals, nursing homes and certified nursing facilities; (iii) qualifications and training of staff of hospitals, nursing homes and certified nursing facilities, except those professionals licensed or certified by the Department of Health Professions; (iv) conditions under which a hospital or nursing home may provide medical and nursing services to patients in their places of residence; and (v) policies related to infection prevention, disaster preparedness, and facility security of hospitals, nursing homes, and certified nursing facilities;

2. Shall provide that at least one physician who is licensed to practice medicine in this Commonwealth shall be on call at all times, though not necessarily physically present on the premises, at each hospital which operates or holds itself out as operating an emergency service;

3. May classify hospitals and nursing homes by type of specialty or service and may provide for licensing hospitals and nursing homes by bed capacity and by type of specialty or service;

4. Shall also require that each hospital establish a protocol for organ donation, in compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services (CMS), particularly 42 C.F.R. § 482.45. Each hospital shall have an agreement with an organ procurement organization designated in CMS regulations for routine contact, whereby the provider's designated organ procurement organization certified by CMS (i) is notified in a timely manner of all deaths or imminent deaths of patients in the hospital and (ii) is authorized to determine the suitability of the decedent or patient for organ donation and, in the absence of a similar arrangement with any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks, the suitability for tissue and eye donation. The hospital shall also have an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage, and distribution of tissues and eyes to ensure that all usable tissues and eyes are obtained from potential donors and to avoid interference with organ procurement. The protocol shall ensure that the hospital collaborates with the designated organ procurement organization to inform the family of each potential donor of the option to donate organs, tissues, or eyes or to decline to donate. The individual making contact with the family shall have completed a course in the methodology for approaching potential donor families and requesting organ or tissue donation that (a) is offered or approved by the organ procurement organization and designed in conjunction with the tissue and eye bank community and (b) encourages discretion and sensitivity according to the specific circumstances, views, and beliefs of the relevant family. In addition, the hospital shall work cooperatively with the designated organ procurement organization in educating the staff responsible for contacting the organ procurement organization's personnel on donation issues, the proper review of death records to improve identification of potential donors, and the proper procedures for maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. This process shall be followed, without exception, unless the family of the relevant decedent or patient has expressed opposition to organ donation, the chief administrative officer of the hospital or his designee knows of such opposition, and no donor card or other relevant document, such as an advance directive, can be found;

5. Shall require that each hospital that provides obstetrical services establish a protocol for admission or transfer of any pregnant woman who presents herself while in labor;

6. Shall also require that each licensed hospital develop and implement a protocol requiring written discharge plans for identified, substance-abusing, postpartum women and their infants. The protocol shall require that the discharge plan be discussed with the patient and that appropriate referrals for the mother and the infant be made and documented. Appropriate referrals may include, but need not be limited to, treatment services, comprehensive early intervention services for infants and toddlers with disabilities and their families pursuant to Part H of the Individuals with Disabilities Education Act, 20 U.S.C. § 1471 et seq., and family-oriented prevention services. The discharge planning process shall

involve, to the extent possible, the other parent of the infant and any members of the patient's extended family who may participate in the follow-up care for the mother and the infant. Immediately upon identification, pursuant to § 54.1-2403.1, of any substance-abusing, postpartum woman, the hospital shall notify, subject to federal law restrictions, the community services board of the jurisdiction in which the woman resides to appoint a discharge plan manager. The community services board shall implement and manage the discharge plan;

7. Shall require that each nursing home and certified nursing facility fully disclose to the applicant for admission the home's or facility's admissions policies, including any preferences given;

8. Shall require that each licensed hospital establish a protocol relating to the rights and responsibilities of patients which shall include a process reasonably designed to inform patients of such rights and responsibilities. Such rights and responsibilities of patients, a copy of which shall be given to patients on admission, shall be consistent with applicable federal law and regulations of the Centers for Medicare and Medicaid Services;

9. Shall establish standards and maintain a process for designation of levels or categories of care in neonatal services according to an applicable national or state-developed evaluation system. Such standards may be differentiated for various levels or categories of care and may include, but need not be limited to, requirements for staffing credentials, staff/patient ratios, equipment, and medical protocols;

10. Shall require that each nursing home and certified nursing facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report;

11. Shall permit hospital personnel, as designated in medical staff bylaws, rules and regulations, or hospital policies and procedures, to accept emergency telephone and other verbal orders for medication or treatment for hospital patients from physicians, and other persons lawfully authorized by state statute to give patient orders, subject to a requirement that such verbal order be signed, within a reasonable period of time not to exceed 72 hours as specified in the hospital's medical staff bylaws, rules and regulations or hospital policies and procedures, by the person giving the order, or, when such person is not available within the period of time specified, co-signed by another physician or other person authorized to give the order;

12. Shall require, unless the vaccination is medically contraindicated or the resident declines the offer of the vaccination, that each certified nursing facility and nursing home provide or arrange for the administration to its residents of (i) an annual vaccination against influenza and (ii) a pneumococcal vaccination, in accordance with the most recent recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

13. Shall require that each nursing home and certified nursing facility register with the Department of State Police to receive notice of the registration, reregistration, or verification of registration information of any person required to register with the Sex Offender and Crimes Against Minors Registry pursuant

to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1 within the same or a contiguous zip code area in which the home or facility is located, pursuant to § 9.1-914;

14. Shall require that each nursing home and certified nursing facility ascertain, prior to admission, whether a potential patient is required to register with the Sex Offender and Crimes Against Minors Registry pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, if the home or facility anticipates the potential patient will have a length of stay greater than three days or in fact stays longer than three days;

15. Shall require that each licensed hospital include in its visitation policy a provision allowing each adult patient to receive visits from any individual from whom the patient desires to receive visits, subject to other restrictions contained in the visitation policy including, but not limited to, those related to the patient's medical condition and the number of visitors permitted in the patient's room simultaneously;

16. Shall require that each nursing home and certified nursing facility shall, upon the request of the facility's family council, send notices and information about the family council mutually developed by the family council and the administration of the nursing home or certified nursing facility, and provided to the facility for such purpose, to the listed responsible party or a contact person of the resident's choice up to six times per year. Such notices may be included together with a monthly billing statement or other regular communication. Notices and information shall also be posted in a designated location within the nursing home or certified nursing facility. No family member of a resident or other resident representative shall be restricted from participating in meetings in the facility with the families or resident representatives of other residents in the facility;

17. Shall require that each nursing home and certified nursing facility maintain liability insurance coverage in a minimum amount of $1 million, and professional liability coverage in an amount at least equal to the recovery limit set forth in § 8.01-581.15, to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the facility. Failure to maintain such minimum insurance shall result in revocation of the facility's license;

18. Shall require each hospital that provides obstetrical services to establish policies to follow when a stillbirth, as defined in § 32.1-69.1, occurs that meet the guidelines pertaining to counseling patients and their families and other aspects of managing stillbirths as may be specified by the Board in its regulations;

19. Shall require each nursing home to provide a full refund of any unexpended patient funds on deposit with the facility following the discharge or death of a patient, other than entrance-related fees paid to a continuing care provider as defined in § 38.2-4900, within 30 days of a written request for such funds by the discharged patient or, in the case of the death of a patient, the person administering the person's estate in accordance with the Virginia Small Estates Act (§ 64.2-600 et seq.);

20. Shall require that each hospital that provides inpatient psychiatric services establish a protocol that requires, for any refusal to admit (i) a medically stable patient referred to its psychiatric unit, direct

verbal communication between the on-call physician in the psychiatric unit and the referring physician, if requested by such referring physician, and prohibits on-call physicians or other hospital staff from refusing a request for such direct verbal communication by a referring physician and (ii) a patient for whom there is a question regarding the medical stability or medical appropriateness of admission for inpatient psychiatric services due to a situation involving results of a toxicology screening, the on-call physician in the psychiatric unit to which the patient is sought to be transferred to participate in direct verbal communication, either in person or via telephone, with a clinical toxicologist or other person who is a Certified Specialist in Poison Information employed by a poison control center that is accredited by the American Association of Poison Control Centers to review the results of the toxicology screen and determine whether a medical reason for refusing admission to the psychiatric unit related to the results of the toxicology screen exists, if requested by the referring physician;

21. Shall require that each hospital that is equipped to provide life-sustaining treatment shall develop a policy governing determination of the medical and ethical appropriateness of proposed medical care, which shall include (i) a process for obtaining a second opinion regarding the medical and ethical appropriateness of proposed medical care in cases in which a physician has determined proposed care to be medically or ethically inappropriate; (ii) provisions for review of the determination that proposed medical care is medically or ethically inappropriate by an interdisciplinary medical review committee and a determination by the interdisciplinary medical review committee regarding the medical and ethical appropriateness of the proposed health care; and (iii) requirements for a written explanation of the decision reached by the interdisciplinary medical review committee, which shall be included in the patient's medical record. Such policy shall ensure that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 (a) are informed of the patient's right to obtain his medical record and to obtain an independent medical opinion and (b) afforded reasonable opportunity to participate in the medical review committee meeting. Nothing in such policy shall prevent the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986 from obtaining legal counsel to represent the patient or from seeking other remedies available at law, including seeking court review, provided that the patient, his agent, or the person authorized to make medical decisions pursuant to § 54.1-2986, or legal counsel provides written notice to the chief executive officer of the hospital within 14 days of the date on which the physician's determination that proposed medical treatment is medically or ethically inappropriate is documented in the patient's medical record;

22. Shall require every hospital with an emergency department to establish a security plan. Such security plan shall be developed using standards established by the International Association for Healthcare Security and Safety or other industry standard and shall be based on the results of a security risk assessment of each emergency department location of the hospital and shall include the presence of at least one off-duty law-enforcement officer or trained security personnel who is present in the emergency department at all times as indicated to be necessary and appropriate by the security risk assessment. Such security plan shall be based on identified risks for the emergency department,

including trauma level designation, overall volume, volume of psychiatric and forensic patients, incidents of violence against staff, and level of injuries sustained from such violence, and prevalence of crime in the community, in consultation with the emergency department medical director and nurse director. The security plan shall also outline training requirements for security personnel in the potential use of and response to weapons, defensive tactics, de-escalation techniques, appropriate physical restraint and seclusion techniques, crisis intervention, and trauma-informed approaches. Such training shall also include instruction on safely addressing situations involving patients, family members, or other persons who pose a risk of harm to themselves or others due to mental illness or substance abuse or who are experiencing a mental health crisis. Such training requirements may be satisfied through completion of the Department of Criminal Justice Services minimum training standards for auxiliary police officers as required by § 15.2-1731. The Commissioner shall provide a waiver from the requirement that at least one off-duty law-enforcement officer or trained security personnel be present at all times in the emergency department if the hospital demonstrates that a different level of security is necessary and appropriate for any of its emergency departments based upon findings in the security risk assessment;

23. Shall require that each hospital establish a protocol requiring that, before a health care provider arranges for air medical transportation services for a patient who does not have an emergency medical condition as defined in 42 U.S.C. § 1395dd(e)(1), the hospital shall provide the patient or his authorized representative with written or electronic notice that the patient (i) may have a choice of transportation by an air medical transportation provider or medically appropriate ground transportation by an emergency medical services provider and (ii) will be responsible for charges incurred for such transportation in the event that the provider is not a contracted network provider of the patient's health insurance carrier or such charges are not otherwise covered in full or in part by the patient's health insurance plan;

24. Shall establish an exemption from the requirement to obtain a license to add temporary beds in an existing hospital or nursing home, including beds located in a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health;

25. Shall establish protocols to ensure that any patient scheduled to receive an elective surgical procedure for which the patient can reasonably be expected to require outpatient physical therapy as a follow-up treatment after discharge is informed that he (i) is expected to require outpatient physical

therapy as a follow-up treatment and (ii) will be required to select a physical therapy provider prior to being discharged from the hospital;

26. Shall permit nursing home staff members who are authorized to possess, distribute, or administer medications to residents to store, dispense, or administer cannabis oil to a resident who has been issued a valid written certification for the use of cannabis oil in accordance with § 4.1-1601;

27. Shall require each hospital with an emergency department to establish a protocol for the treatment and discharge of individuals experiencing a substance use-related emergency, which shall include provisions for (i) appropriate screening and assessment of individuals experiencing substance use-related emergencies to identify medical interventions necessary for the treatment of the individual in the emergency department and (ii) recommendations for follow-up care following discharge for any patient identified as having a substance use disorder, depression, or mental health disorder, as appropriate, which may include, for patients who have been treated for substance use-related emergencies, including opioid overdose, or other high-risk patients, (a) the dispensing of naloxone or other opioid antagonist used for overdose reversal pursuant to subsection X of § 54.1-3408 at discharge or (b) issuance of a prescription for and information about accessing naloxone or other opioid antagonist used for overdose reversal, including information about accessing naloxone or other opioid antagonist used for overdose reversal at a community pharmacy, including any outpatient pharmacy operated by the hospital, or through a community organization or pharmacy that may dispense naloxone or other opioid antagonist used for overdose reversal without a prescription pursuant to a statewide standing order. Such protocols may also provide for referrals of individuals experiencing a substance use-related emergency to peer recovery specialists and community-based providers of behavioral health services, or to providers of pharmacotherapy for the treatment of drug or alcohol dependence or mental health diagnoses;

28. During a public health emergency related to COVID-19, shall require each nursing home and certified nursing facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the nursing home, certified nursing facility, and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of the patients and staff of the nursing home or certified nursing facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subdivision; and (iv) the steps the nursing home or certified nursing facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subdivision. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's

personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each nursing home and certified nursing facility publish on its website or communicate to each patient or the patient's authorized representative, in writing or via electronic means, the nursing home's or certified nursing facility's plan for providing visits to patients as required by this subdivision;

29. Shall require each hospital, nursing home, and certified nursing facility to establish and implement policies to ensure the permissible access to and use of an intelligent personal assistant provided by a patient, in accordance with such regulations, while receiving inpatient services. Such policies shall ensure protection of health information in accordance with the requirements of the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d et seq., as amended. For the purposes of this subdivision, "intelligent personal assistant" means a combination of an electronic device and a specialized software application designed to assist users with basic tasks using a combination of natural language processing and artificial intelligence, including such combinations known as "digital assistants" or "virtual assistants";

30. During a declared public health emergency related to a communicable disease of public health threat, shall require each hospital, nursing home, and certified nursing facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subdivision to comply with all reasonable requirements of the hospital, nursing home, or certified nursing facility adopted to protect the health and safety of the person, patients, and staff of the hospital, nursing home, or certified nursing facility;

31. Shall require that every hospital that makes health records, as defined in § 32.1-127.1:03, of patients who are minors available to such patients through a secure website shall make such health records available to such patient's parent or guardian through such secure website, unless the hospital cannot make such health record available in a manner that prevents disclosure of information, the disclosure of which has been denied pursuant to subsection F of § 32.1-127.1:03 or for which consent required in accordance with subsection E of § 54.1-2969 has not been provided; and

32. Shall require each certified nursing facility eligible to participate in the Virginia Medicaid Nursing Facility Value-Based Purchasing (VBP) program, as referenced in Chapter 2 of the Acts of Assembly of 2022, Special Session I, to provide at least 3.08 hours of case mix-adjusted total nurse staffing hours per resident per day on average as determined annually by the Department of Medical Assistance Services for use in the VBP program, utilizing job codes for the calculation of total nurse staffing hours per resident per day following the Centers for Medicare and Medicaid Services (CMS) definitions as of January 1, 2022, used for similar purposes and including certified nursing assistants,

licensed practical nurses, and registered nurses. No additional reporting shall be required by a certified nursing facility under this subdivision.

C. Upon obtaining the appropriate license, if applicable, licensed hospitals, nursing homes, and certified nursing facilities may operate adult day care centers.

D. All facilities licensed by the Board pursuant to this article which provide treatment or care for hemophiliacs and, in the course of such treatment, stock clotting factors, shall maintain records of all lot numbers or other unique identifiers for such clotting factors in order that, in the event the lot is found to be contaminated with an infectious agent, those hemophiliacs who have received units of this contaminated clotting factor may be apprised of this contamination. Facilities which have identified a lot that is known to be contaminated shall notify the recipient's attending physician and request that he notify the recipient of the contamination. If the physician is unavailable, the facility shall notify by mail, return receipt requested, each recipient who received treatment from a known contaminated lot at the individual's last known address.

E. Hospitals in the Commonwealth may enter into agreements with the Department of Health for the provision to uninsured patients of naloxone or other opioid antagonists used for overdose reversal.

Code 1950, § 32-301; 1972, c. 36; 1979, c. 711; 1985, c. 335; 1986, c. 135; 1987, c. 224; 1988, cc. 325, 418; 1989, cc. 434, 618, 699; 1992, cc. 334, 428; 1993, c. 335; 1996, cc. 361, 411; 1997, c. 454; 1998, c. 450; 2000, cc. 176, 810; 2001, c. 463; 2004, c. 762; 2007, cc. 119, 164, 516; 2011, cc. 406, 412, 670; 2013, c. 320; 2014, c. 320; 2015, c. 661; 2016, c. 85; 2017, cc. 175, 462; 2018, cc. 271, 368, 454, 565, 682, 791; 2019, cc. 136, 343; 2020, cc. 714, 829, 846, 898, 899, 900, 942; 2020, Sp. Sess. I, cc. 10, 11; 2021, Sp. Sess. I, cc. 219, 233, 525; 2022, cc. 218, 712, 772; 2023, cc. 417, 482, 483, 740, 773.

§ 32.1-127.001. Certain design and construction standards to be incorporated in hospital and nursing home licensure regulations.

Notwithstanding any law or regulation to the contrary, the Board of Health shall promulgate regulations pursuant to § 32.1-127 for the licensure of hospitals and nursing homes that shall include minimum standards for the design and construction of hospitals, nursing homes, and certified nursing facilities consistent with the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities issued by the American Institute of Architects Academy of Architecture for Health.

2005, cc. 177, 222.

§ 32.1-127.01. Regulations to authorize certain sanctions and guidelines.

The regulations established pursuant to § 32.1-127 shall authorize the Commissioner to initiate court proceedings against nursing homes and certified nursing facilities, except for facilities or units certified as facilities for individuals with intellectual disability. Such proceedings may be initiated by themselves or in conjunction with the administrative sanctions provided in § 32.1-135.

The Board shall promulgate guidelines for the Commissioner to determine when the imposition of administrative sanctions or initiation of court proceedings as specified in § 32.1-27.1, or both, are appropriate in order to ensure prompt correction of violations involving noncompliance with requirements of state or federal law or regulation as discovered on any inspection conducted by the Department of Health pursuant to the provisions of this article or the provisions of Title XVIII or Title XIX of the Social Security Act or as discovered on any inspection conducted by the Department of Medical Assistance Services pursuant to Title XIX of the Social Security Act.

1989, c. 618; 2012, cc. 476, 507.

§ 32.1-127.1. Immunity from liability for routine referral for organ and tissue donation.

Any chief administrative officer of a hospital or his designee who administers the routine referral required by § 32.1-127 and any representative of any organ procurement organization or eye or tissue bank who receives notice of a death or imminent death, determines the suitability of the decedent or patient for organ donation, makes contact with the family of a decedent or patient to request the donation of organs, tissues or eyes, or assists or performs the removal of any donated organs, tissues or eyes shall be immune from civil liability for any act, decision, or omission or statement made in accordance with the provisions of § 32.1-127, the regulations of the Board, and the provisions of the Health Care Financing Administration's regulations on routine referral and organ donation, unless he was grossly negligent or acted in bad faith or with malicious intent.

1988, cc. 325, 418; 2000, c. 810.

§ 32.1-127.1:01. Record storage.

A. Health records, as defined in § 32.1-127.1:03, may be stored by computerized or other electronic process or microfilm, or other photographic, mechanical, or chemical process; however, the stored record shall identify the location of any documents or information that could not be so technologically stored. If the technological storage process creates an unalterable record, the nursing facility, hospital or other licensed health care provider shall not be required to maintain paper copies of health records that have been stored by computerized or other electronic process, microfilm, or other photographic, mechanical, or chemical process. Upon completing such technological storage, paper copies of health records may be destroyed in a manner that preserves the patient's confidentiality. However, any documents or information that could not be so technologically stored shall be preserved.

B. Notwithstanding the authority of this section to copy health records in the form of microfilm, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412.

1994, c. 390; 1998, c. 470; 2012, c. 336.

§ 32.1-127.1:02. Repealed.

Repealed by Acts 1997, c. 682.

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by other provisions of state law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, including an audit trail of any additions, deletions, or revisions to the health record, if specifically requested, except as provided in subsections E and F and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

4. Health care entities shall, upon the request of the individual who is the subject of the health record, disclose health records to other health care entities, in any available format of the requester's choosing, as provided in subsection E.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" includes any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" does not include annotations relating to medication and prescription monitoring, counseling session start and stop times,

treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors;

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3; or

4. The release of health records to a state correctional facility pursuant to § 53.1-40.10 or a local or regional correctional facility pursuant to § 53.1-133.03.

D. Health care entities may, and, when required by other provisions of state law, shall, disclose health records:

1. As set forth in subsection E, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969 or (b) the minor himself, if he has consented to his own treatment pursuant to § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H, pursuant to a search warrant or a grand jury subpoena, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413. Regardless of the manner by which health records relating to an individual are compelled to be disclosed pursuant to this subdivision, nothing in this subdivision shall be construed to prohibit any staff or employee of a health care entity from providing information about such individual to a law-enforcement officer in connection with such subpoena, search warrant, or court order;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to,

those contained in §§ 16.1-248.3, 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 32.1-320, 37.2-710, 37.2-839, 53.1-40.10, 53.1-133.03, 54.1-2400.6, 54.1-2400.7, 54.1-2400.9, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2967, 54.1-2968, 54.1-3408.2, 63.2-1509, and 63.2-1606;

7. Where necessary in connection with the care of the individual;

8. In connection with the health care entity's own health care operations or the health care operations of another health care entity, as specified in 45 C.F.R. § 164.501, or in the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2;

12. To the guardian ad litem and any attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a commitment proceeding under § 19.2-169.6, Article 5 (§ 37.2-814 et seq.) of Chapter 8 of Title 37.2, Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, or a judicial authorization for treatment proceeding pursuant to Chapter 11 (§ 37.2-1100 et seq.) of Title 37.2;

13. To a magistrate, the court, the evaluator or examiner required under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or § 37.2-815, a community services board or behavioral health authority or a designee of a community services board or behavioral health authority, or a law-enforcement officer participating in any proceeding under Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1, § 19.2-169.6, or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 regarding the subject of the proceeding, and to any health care provider evaluating or providing services to the person who is the subject of the proceeding or monitoring the person's adherence to a treatment plan ordered under those provisions. Health records disclosed to a law-enforcement officer shall be limited to information necessary to protect the officer, the person, or the public from physical injury or to address the health care needs of the person. Information disclosed to a law-enforcement officer shall not be used for any other purpose, disclosed to others, or retained;

14. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting

the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

15. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

16. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

17. To third-party payors and their agents for purposes of reimbursement;

18. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

19. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

20. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

21. Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;

22. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

23. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

24. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

25. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration

and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

26. To the Office of the State Inspector General pursuant to Chapter 3.2 (§ 2.2-307 et seq.) of Title 2.2;

27. To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4, pursuant to subdivision 1;

28. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

29. To law-enforcement officials, in response to their request, for the purpose of identifying or locating a suspect, fugitive, person required to register pursuant to § 9.1-901 of the Sex Offender and Crimes Against Minors Registry Act, material witness, or missing person, provided that only the following information may be disclosed: (i) name and address of the person, (ii) date and place of birth of the person, (iii) social security number of the person, (iv) blood type of the person, (v) date and time of treatment received by the person, (vi) date and time of death of the person, where applicable, (vii) description of distinguishing physical characteristics of the person, and (viii) type of injury sustained by the person;

30. To law-enforcement officials regarding the death of an individual for the purpose of alerting law enforcement of the death if the health care entity has a suspicion that such death may have resulted from criminal conduct;

31. To law-enforcement officials if the health care entity believes in good faith that the information disclosed constitutes evidence of a crime that occurred on its premises;

32. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2;

33. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment;

34. To notify a family member or personal representative of an individual who is the subject of a proceeding pursuant to Article 16 (§ 16.1-335 et seq.) of Chapter 11 of Title 16.1 or Chapter 8 (§ 37.2-800 et seq.) of Title 37.2 of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition, when the individual has the capacity to make health care decisions and (i) the individual has agreed to the notification, (ii) the individual has been provided an opportunity to object to the notification and does not express an objection, or (iii) the health care provider can, on the basis of his professional

judgment, reasonably infer from the circumstances that the individual does not object to the notification. If the opportunity to agree or object to the notification cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the health care provider may notify a family member or personal representative of the individual of information that is directly relevant to such person's involvement with the individual's health care, which may include the individual's location and general condition if the health care provider, in the exercise of his professional judgment, determines that the notification is in the best interests of the individual. Such notification shall not be made if the provider has actual knowledge the family member or personal representative is currently prohibited by court order from contacting the individual;

35. To a threat assessment team established by a local school board pursuant to § 22.1-79.4, by a public institution of higher education pursuant to § 23.1-805, or by a private nonprofit institution of higher education; and

36. To a regional emergency medical services council pursuant to § 32.1-116.1, for purposes limited to monitoring and improving the quality of emergency medical services pursuant to § 32.1-111.3.

Notwithstanding the provisions of subdivisions 1 through 35, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of § 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Health care records required to be disclosed pursuant to this section shall be made available electronically only to the extent and in the manner authorized by the federal Health Information Technology for Economic and Clinical Health Act (P.L. 111-5) and implementing regulations and the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.) and implementing regulations. Notwithstanding any other provision to the contrary, a health care entity shall not be required to provide records in an electronic format requested if (i) the electronic format is not reasonably available without additional cost to the health care entity, (ii) the records would be subject to modification in the format requested, or (iii) the health care entity determines that the integrity of the records could be compromised in the electronic format requested. Requests for copies of or electronic access to health records shall (a) be in writing, dated and signed by the requester; (b) identify the nature of the information requested; and (c) include evidence of the authority of the requester to receive such copies or access such records, and identification of the person to whom the information is to be disclosed; and (d) specify whether the requester would like the records in electronic format, if available, or in paper format. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed

by the requester as if it were an original. Within 30 days of receipt of a request for copies of or electronic access to health records, the health care entity shall do one of the following: (1) furnish such copies of or allow electronic access to the requested health records to any requester authorized to receive them in electronic format if so requested; (2) inform the requester if the information does not exist or cannot be found; (3) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (4) deny the request (A) under subsection F, (B) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (C) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of state law.

F. Except as provided in subsection B of § 8.01-413, copies of or electronic access to an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of or electronic access to health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical social worker, or licensed professional counselor upon whose opinion the denial is based. The designated reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician, clinical psychologist, clinical social worker, or licensed professional counselor, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician, clinical psychologist, clinical social worker, or licensed professional counselor upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor. The health care entity shall permit copying and examination of the health record by such other physician, clinical psychologist, clinical social worker, or licensed professional counselor designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician, clinical psychologist, clinical social worker, or licensed professional counselor shall be accompanied by a statement from the custodian of the health record that the individual's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name _____

Health Care Entity's Name _____

Person, Agency, or Health Care Entity to whom disclosure is to be made

_____

Information or Health Records to be disclosed

_____

Purpose of Disclosure or at the Request of the Individual

_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event) _____

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

_____

Relationship or Authority of Legal Representative

_____

Date of Signature _____

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health

records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE

SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivision 5 or 8 from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted

health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

K. Nothing in this section shall prohibit a health care provider who prescribes or dispenses a controlled substance required to be reported to the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 to a patient from disclosing information obtained from the Prescription Monitoring Program and contained in a patient's health care record to another health care provider when such disclosure is related to the care or treatment of the patient who is the subject of the record.

L. An authorization for the disclosure of health records executed pursuant to this section shall remain in effect until (i) the authorization is revoked in writing and delivered to the health care entity maintaining the record that is subject to the authorization by the person who executed the authorization, (ii) any expiration date set forth in the authorization, or (iii) the health care entity maintaining the record becomes aware of any expiration event described in the authorization, whichever occurs first. However, any revocation of an authorization for the disclosure of health records executed pursuant to this section shall not be effective to the extent that the health care entity maintaining the record has disclosed health records prior to delivery of such revocation in reliance upon the authorization or as otherwise provided pursuant to 45 C.F.R. § 164.508. A statement in an authorization for the disclosure of

health records pursuant to this section that the information to be used or disclosed is "all health records" is a sufficient description for the disclosure of all health records of the person maintained by the health care provider to whom the authorization was granted. If a health care provider receives a written revocation of an authorization for the disclosure of health records in accordance with this subsection, a copy of such written revocation shall be included in the person's original health record maintained by the health care provider.

An authorization for the disclosure of health records executed pursuant to this section shall, unless otherwise expressly limited in the authorization, be deemed to include authorization for the person named in the authorization to assist the person who is the subject of the health record in accessing health care services, including scheduling appointments for the person who is the subject of the health record and attending appointments together with the person who is the subject of the health record.

1997, c. 682; 1998, c. 470; 1999, cc. 812, 956, 1010; 2000, cc. 810, 813, 923, 927; 2001, c. 671; 2002, cc. 568, 658, 835, 860; 2003, cc. 471, 907, 983; 2004, cc. 49, 64, 65, 66, 67, 163, 773, 1014, 1021; 2005, cc. 39, 101, 642, 697; 2006, c. 433; 2007, c. 497; 2008, cc. 315, 782, 850, 870; 2009, cc. 606, 651, 813, 840; 2010, cc. 185, 340, 406, 456, 524, 778, 825; 2011, cc. 499, 668, 798, 812, 844, 871; 2012, cc. 386, 402, 479; 2016, c. 554; 2017, cc. 457, 712, 720; 2018, c. 165; 2020, c. 945; 2022, cc. 509, 534, 784.

§ 32.1-127.1:04. Use or disclosure of certain protected health information required.

A. The coordination of prevention and control of disease, injury, or disability and the delivery of health care benefits are hereby declared to be (i) necessary public health activities; (ii) necessary health oversight activities for the integrity of the health care system; and (iii) necessary to prevent serious harm and serious threats to the health and safety of individuals and the public.

B. The Departments of Health, Medical Assistance Services, Behavioral Health and Developmental Services, and Social Services, and the Departments for Aging and Rehabilitative Services, the Blind and Vision Impaired, and the Deaf and Hard-of-Hearing, or any successors in interest thereof shall establish a secure system for sharing protected health information that may be necessary for the coordination of prevention and control of disease, injury, or disability and for the delivery of health care benefits when such protected information concerns individuals who (i) have contracted a reportable disease, including exposure to a toxic substance, as required by the Board of Health pursuant to § 32.1-35 or other disease or disability required to be reported by law; (ii) are the subjects of public health surveillance, public health investigations, or public health interventions or are applicants for or recipients of medical assistance services; (iii) have been or are the victims of child abuse or neglect or domestic violence; or (iv) may present a serious threat to health or safety of a person or the public or may be subject to a serious threat to their health or safety. For the purposes of this section, "public health interventions" shall include the services provided through the Departments for Aging and Rehabilitative Services, the Blind and Vision Impaired, and the Deaf and Hard-of-Hearing, or any successors in interest thereof.

Pursuant to the regulations concerning patient privacy promulgated by the federal Department of Health and Human Services, covered entities may disclose protected health information to the secure system without obtaining consent or authorization for such disclosure. Such protected health information shall be used exclusively for the purposes established in this section.

C. The Office of the Attorney General shall advise the Departments of Health, Medical Assistance Services, Behavioral Health and Developmental Services, and Social Services and the Departments for Aging and Rehabilitative Services, the Blind and Vision Impaired, and the Deaf and Hard-of-Hearing, or any successors in interest thereof, in the implementation of this section.

2002, c. 835; 2003, c. 464; 2009, cc. 813, 840; 2012, cc. 803, 835.

§ 32.1-127.1:05. Breach of medical information notification.

A. As used in this section:

"Breach of the security of the system" means unauthorized access and acquisition of unencrypted and unredacted computerized data that compromises the security, confidentiality, or integrity of medical information maintained by an entity. Good faith acquisition of medical information by an employee or agent of an entity for the purposes of the entity is not a breach of the security of the system, provided that the medical information is not used for a purpose other than a lawful purpose of the entity or subject to further unauthorized disclosure.

"Encrypted" means the transformation of data through the use of an algorithmic process into a form in which there is a low probability of assigning meaning without the use of a confidential process or key, or the securing of the information by another method that renders the data elements unreadable or unusable.

"Entity" means any authority, board, bureau, commission, district or agency of the Commonwealth or of any political subdivision of the Commonwealth, including cities, towns and counties, municipal councils, governing bodies of counties, school boards and planning commissions; boards of visitors of public institutions of higher education; and other organizations, corporations, or agencies in the Commonwealth supported wholly or principally by public funds.

"Medical information" means the first name or first initial and last name in combination with and linked to any one or more of the following data elements that relate to a resident of the Commonwealth, when the data elements are neither encrypted nor redacted:

1. Any information regarding an individual's medical or mental health history, mental or physical condition, or medical treatment or diagnosis by a health care professional; or

2. An individual's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the individual, or any information in an individual's application and claims history, including any appeals records.

The term does not include information that is lawfully obtained from publicly available information, or from federal, state, or local government records lawfully made available to the general public.

"Notice" means:

1. Written notice to the last known postal address in the records of the entity;

2. Telephone notice;

3. Electronic notice; or

4. Substitute notice, if the entity required to provide notice demonstrates that the cost of providing notice will exceed $50,000, the affected class of Virginia residents to be notified exceeds 100,000 residents, or the entity does not have sufficient contact information or consent to provide notice as described in subdivisions 1, 2, or 3 of this definition. Substitute notice consists of the following:

a. E-mail notice if the entity has e-mail addresses for the members of the affected class of residents;

b. Conspicuous posting of the notice on the website of the entity if the entity maintains a website; and

c. Notice to major statewide media.

Notice required by this section shall include a description of the following:

(1) The incident in general terms;

(2) The type of medical information that was subject to the unauthorized access and acquisition;

(3) The general acts of the entity to protect the personal information from further unauthorized access; and

(4) A telephone number that the person may call for further information and assistance, if one exists.

"Redact" means alteration or truncation of data such that no information regarding an individual's medical history, mental or physical condition, or medical treatment or diagnosis or no more than four digits of a health insurance policy number, subscriber number, or other unique identifier are accessible as part of the medical information.

B. If unencrypted or unredacted medical information was or is reasonably believed to have been accessed and acquired by an unauthorized person, an entity that owns or licenses computerized data that includes medical information shall disclose any breach of the security of the system following discovery or notification of the breach of the security of the system to the Office of the Attorney General, the Commissioner of Health, the subject of the medical information, and any affected resident of the Commonwealth without unreasonable delay. Notice required by this section may be reasonably delayed to allow the entity to determine the scope of the breach of the security of the system and restore the reasonable integrity of the system. Notice required by this section may be delayed if, after the entity notifies a law-enforcement agency, the law-enforcement agency determines and advises the entity that the notice will impede a criminal or civil investigation, or homeland or national security. Notice shall be made without unreasonable delay after the law-enforcement agency determines that the notification will no longer impede the investigation or jeopardize national or homeland security.

C. An entity shall disclose the breach of the security of the system if encrypted information is accessed and acquired in an unencrypted form, or if the security breach involves a person with access to the encryption key.

D. An entity that maintains computerized data that includes medical information that the entity does not own or license shall notify the owner or licensee of the information of any breach of the security of the system without unreasonable delay following discovery of the breach of the security of the system, if the medical information was accessed and acquired by an unauthorized person or the entity reasonably believes the medical information was accessed and acquired by an unauthorized person.

E. In the event an entity provides notice to more than 1,000 persons at one time, pursuant to this section, the entity shall notify, without unreasonable delay, the Office of the Attorney General and the Commissioner of Health of the timing, distribution, and content of the notice.

F. This section shall not apply to (i) a person or entity who is a "covered entity" or "business associate" under the Health Insurance Portability and Accountability Act of 1996 (42 USC § 1320d et seq.) and is subject to requirements for notification in the case of a breach of protected health information (42 USC 17932 et seq.) or (ii) a person or entity who is a non-HIPAA-covered entity subject to the Health Breach Notification Rule promulgated by the Federal Trade Commission pursuant to 42 USC § 17937 et seq.

G. An entity that complies with the notification requirements or procedures pursuant to the rules, regulations, procedures, and guidelines established by the entity's primary or functional state or federal regulator shall be in compliance with this section.

2010, c. 852.

§ 32.1-127.2. Repealed.

Repealed by Acts 1991, c. 94.

§ 32.1-127.3. Immunity from liability for certain free health care services.

A. No hospital employee who renders health care services at his place of employment and within the limits of his licensure, certification, or multistate licensure privilege to practice nursing, or, if such employee is not required to be licensed or certified pursuant to Title 54.1, within the scope of his employment, shall be liable for any civil damages for any act or omission resulting from the rendering of such services to a patient of a clinic which is organized in whole or in part for the delivery of health care services without charge unless such act or omission was the result of gross negligence or willful misconduct. Such clinic shall have on record written agreements with each hospital providing such services, and immunity shall apply only to those services provided by the hospital without charge.

B. For the purposes of Article 5 (§ 2.2-1832 et seq.) of Chapter 18 of Title 2.2, any personnel employed by a hospital licensed pursuant to this article and rendering health care services pursuant to subsection A shall be deemed an agent of the Commonwealth and to be acting in an authorized governmental capacity with respect to delivery of such health care services if (i) the hospital has agreed in writing to provide health care services at no charge for patients referred by a clinic organized in whole

or in part for the delivery of health care services without charge, (ii) the employing hospital is registered with the Division of Risk Management, and (iii) the employee delivering such services has no legal or financial interest in the clinic from which the patient is referred. The premium for coverage of such hospital employees under the Risk Management Plan shall be paid by the Department of Health.

C. The provisions of this section shall only apply to health care personnel providing care pursuant to subsections A and B during the period in which such care is rendered.

D. Moreover, no officer, director or employee of any such clinic, or the clinic itself, as described in subsection A shall, in the absence of gross negligence or willful misconduct, be liable for civil damages resulting from any act or omission relating to the providing of health care services without charge to patients of the clinic.

E. For the purposes of this section and Article 5 (§ 2.2-1832 et seq.) of Chapter 18 of Title 2.2, "delivery of health care services without charge" shall be deemed to include the delivery of dental or medical services in a dental or medical clinic when a reasonable minimum fee is charged to cover administrative costs.

1993, c. 785; 1994, c. 444; 1996, c. 748; 2000, cc. 618, 632; 2004, c. 49.

§ 32.1-128. Applicability to hospitals and nursing homes for practice of religious tenets.

Nothing in this article shall be construed to authorize or require the interference with or prevention of the establishment or operation of a hospital or nursing home for the practice of religious tenets of any recognized church or denomination in the ministration to the sick and suffering by mental or spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation, provided the statutes and regulations on environmental protection and life safety are complied with.

Code 1950, § 32-301; 1972, c. 36; 1979, c. 711.

§ 32.1-129. Application for license.

Each application for a hospital or nursing home license shall be made on a form prescribed by the Board. The application shall specify the official name and the kind of hospital or nursing home, the location thereof, the name of the person in charge and such additional relevant information as the Board requires.

Code 1950, § 32-303; 1972, c. 824; 1979, c. 711.

§ 32.1-130. Service charges.

A. A service charge of $1.50 per patient bed for which the hospital or nursing home is licensed, but not less than $75 nor more than $500, shall be paid for each license upon issuance and renewal. The service charge for a license for a hospital or nursing home which does not provide overnight inpatient care shall be $75.

B. All service charges received under the provisions of this article shall be paid into a special fund of the Department and are appropriated to the Department for the operation of the hospital and nursing home licensure and inspection program.

Code 1950, § 32-304; 1979, c. 711.

§ 32.1-131. Expiration and renewal of licenses.

All licenses shall expire at midnight December 31 of the year issued, or as otherwise specified, and shall be required to be renewed annually.

Code 1950, § 32-304; 1979, c. 711.

§ 32.1-132. Alterations or additions to hospitals and nursing homes; when new license required; use of inpatient hospital beds for furnishing skilled care services.

A. Any person who desires to make any substantial alteration or addition to or any material change in any hospital or nursing home shall, before making such change, alteration or addition, submit the proposal therefor to the Commissioner for his approval. The Commissioner shall review the proposal to determine compliance with applicable statutes and regulations of the Board and as soon thereafter as reasonably practicable notify the person that the proposal is or is not approved.

B. If any such alteration, addition or change has the effect of changing the bed capacity or classification of the hospital or nursing home, the licensee shall obtain a new license for the remainder of the license year before beginning operation of additional beds or in the new classification.

C. Notwithstanding any provision of state law to the contrary, any hospital, after sending such written notice as may be required by the Commissioner, may utilize, for a period not to exceed thirty days for any one patient, a maximum of ten percent of its inpatient hospital beds as swing beds for the furnishing of services of the type which, if furnished by a nursing home or certified nursing facility, would constitute skilled care services without complying with nursing home licensure requirements or retaining the services of a licensed nursing home administrator. Such hospital shall amend its plan of care and implement its plan as amended to ensure the overall well-being of patients occupying such beds. Only those hospitals which qualify under § 1883 of Title XVIII and § 1913 of Title XIX of the Social Security Act and are certified as skilled nursing facilities may be reimbursed for such services for Medicare and Medicaid patients.

Code 1950, § 32-305; 1979, c. 711; 1983, c. 533; 1989, c. 618.

§ 32.1-133. Display of license.

The current license shall at all times be posted in each hospital or nursing home in a place readily visible and accessible to the public.

Code 1950, § 32-306; 1979, c. 711.

§ 32.1-133.1. Human trafficking hotline; posted notice required; civil penalty.

Any health care facility (i) licensed as a hospital pursuant to § 32.1-125 that includes an emergency department or that is a dedicated emergency department as defined in 42 C.F.R. § 489.24(b), (ii)

operating as a clinic which is organized in whole or in part for the delivery of health care services without charge, (iii) licensed as an abortion facility pursuant to § 32.1-127, or (iv) in which the majority of patients are seen without appointments shall post notice of the existence of a human trafficking hotline to alert possible witnesses or victims of human trafficking to the availability of a means to report crimes or gain assistance. The notice required by this section shall be posted in a place readily visible and accessible to the public such as the admitting area or public or patient restrooms of such facility. Such notice shall meet the requirements specified in subsection C of § 40.1-11.3. The State Board shall promulgate regulations necessary to implement the provisions of this section.

2018, c. 571.

§ 32.1-134. Family planning information in hospitals providing maternity care.

Every hospital providing maternity care shall, prior to releasing each maternity patient, make available to such patient family planning information and a list of family planning clinics located in the Commonwealth, unless medically contraindicated; provided, however, that any such hospital operated under the auspices of a religious institution objecting to distributing lists of family planning clinics on religious grounds shall not be required to distribute them. Such information and lists may include, but need not be limited to, such information and lists as shall be furnished by the Department.

Code 1950, § 32-154; 1960, c. 248; 1977, c. 680; 1978, c. 162; 1979, c. 711.

§ 32.1-134.01. Certain information required for maternity patients.

Every licensed nurse midwife, licensed midwife, or hospital providing maternity care shall, prior to releasing each maternity patient, make available to such patient and, if present, to the other parent of the infant and other relevant family members or caretakers, information about the incidence of postpartum blues, perinatal depression, and perinatal anxiety; information to increase awareness of shaken baby syndrome and the dangers of shaking infants; and information about safe sleep environments for infants that is consistent with current information available from the American Academy of Pediatrics. This information shall be discussed with the maternity patient and the other parent of the infant and other relevant family members or caretakers who are present at discharge.

2003, c. 647; 2005, c. 518; 2015, c. 296; 2019, c. 433; 2020, c. 900.

§ 32.1-134.02. Infants; blood sample provided to parents.

Every hospital providing maternity care shall offer to obtain a sample of blood from an infant born at the hospital and provide that sample to the mother of the infant.

2011, c. 621.

§ 32.1-134.1. When denial, etc., to duly licensed physician of staff membership or professional privileges improper.

It shall be an improper practice for the governing body of a hospital which has twenty-five beds or more and which is required by state law to be licensed to refuse or fail to act within sixty days of a completed application for staff membership or professional privileges or deny or withhold from a duly licensed physician staff membership or professional privileges in such hospital, or to exclude or expel

a physician from staff membership in such hospital or curtail, terminate or diminish in any way a physician's professional privileges in such hospital, without stating in writing the reason or reasons therefor, a copy of which shall be provided to the physician. If the reason or reasons stated are unrelated to standards of patient care, patient welfare, violation of the rules and regulations of the institution or staff, the objectives or efficient operations of the institution, or the character or competency of the applicant, or misconduct in any hospital, it shall be deemed an improper practice.

Any physician licensed in this Commonwealth to practice medicine who is aggrieved by any violation of this section shall have the right to seek an injunction from the circuit court of the city or county in which the hospital alleged to have violated this section is located prohibiting any such further violation. The provisions of this section shall not be deemed to impair or affect any other right or remedy; provided that a violation of this section shall not constitute a violation of the provisions of this article for the purposes of § 32.1-135.

1979, c. 711.

§ 32.1-134.2. Clinical privileges for certain practitioners.

The grant or denial of clinical privileges to licensed podiatrists and certified nurse midwives licensed as advanced practice registered nurses pursuant to § 54.1-2957 by any hospital licensed in this Commonwealth, and the determination by the hospital of the scope of such privileges, shall be based upon such practitioner's professional license, experience, competence, ability, and judgment, and the reasonable objectives and regulations of the hospital in which such privileges are sought.

Code 1950, § 32-301.1; 1979, c. 40; 1992, c. 452; 2023, c. 183.

§ 32.1-134.3. Response to applications for clinical privileges.

Whenever a podiatrist or certified nurse midwife licensed as an advanced practice registered nurse makes application to any hospital for clinical privileges, the hospital shall either approve or disapprove the application within 120 calendar days after it has received all necessary information to make a determination as provided in § 32.1-134.2 from the practitioner.

1981, c. 166; 1992, c. 452; 2023, c. 183.

§ 32.1-134.4. Right of podiatrists or advanced practice registered nurses to injunction.

Any licensed podiatrist or certified nurse midwife licensed as an advanced practice registered nurse in Virginia who is aggrieved by any violation of § 32.1-134.2 or § 32.1-134.3 shall have the right to seek an injunction from the circuit court of the city or county in which the hospital alleged to have committed the violation is located, prohibiting any further such violation. The provisions of this section shall not be deemed to impair or affect any other right or remedy. A violation of this section, however, shall not constitute a violation of the provisions of this article for the purposes of § 32.1-135.

1983, c. 259; 1992, c. 452; 2023, c. 183.

§ 32.1-135. Revocation or suspension of license or certification; restriction or prohibition of new admissions to nursing home.

A. In accordance with applicable regulations of the Board, the Commissioner (i) may restrict or prohibit new admissions to any nursing home or certified nursing facility, or (ii) may petition the court to impose a civil penalty against any nursing home or certified nursing facility or to appoint a receiver for such nursing home or certified nursing facility, or both, or (iii) may revoke the certification or may revoke or suspend the license of a hospital or nursing home or the certification of any certified nursing facility for violation of any provision of this article or Article 2 (§ 32.1-138 et seq.) of this chapter or of any applicable regulation promulgated under this chapter or for permitting, aiding, or abetting the commission of any illegal act in the hospital or nursing home.

All appeals from notice of imposition of administrative sanctions shall be received in writing within fifteen days of the date of receipt of such notice. The provisions of the Administrative Process Act (§ 2.2-4000 et seq.) shall be applicable to such appeals.

B. If a license or certification is revoked as herein provided, a new license or certification may be issued by the Commissioner after satisfactory evidence is submitted to him that the conditions upon which revocation was based have been corrected and after proper inspection has been made and compliance with all provisions of this article and applicable state and federal law and regulations hereunder has been obtained.

C. Suspension of a license shall in all cases be for an indefinite time. The Commissioner may completely or partially restore a suspended license or certificate when he determines that the conditions upon which suspension was based have been completely or partially corrected and that the interests of the public will not be jeopardized by resumption of operation. No additional service charges shall be required for restoring such license.

Code 1950, § 32-307; 1979, c. 711; 1989, c. 618.

§ 32.1-135.1. Certain advertisements prohibited.

No hospital licensed under the provisions of this chapter shall include in any advertisement death rate statistics in such manner as to suggest the relative quality of health or hospital services.

1988, c. 85.

§ 32.1-135.2. Offer or payment of remuneration in exchange for referral prohibited.

No hospital licensed pursuant to this chapter shall knowingly and willfully offer or pay any remuneration directly or indirectly, in cash or in kind, to induce any practitioner of the healing arts or any clinical psychologist to refer an individual or individuals to such hospital. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall be developed in conjunction with the State Board of Behavioral Health and Developmental Services and shall be consistent with regulations adopted by such Board pursuant to § 37.2-420. Such regulations shall exclude from the definition of "remuneration" any payments, business arrangements, or payment practices not prohibited by 42 U.S.C. § 1320a, as amended, or any regulations promulgated pursuant thereto.

1990, c. 379; 1996, cc. 937, 980; 2009, cc. 813, 840.

§ 32.1-136. Violation; penalties.

Any person owning, establishing, conducting, maintaining, managing or operating a hospital or nursing home which is not licensed as required by this article shall be guilty of a Class 6 felony.

Code 1950, § 32-310; 1962, c. 551; 1979, c. 711.

§ 32.1-137. Certification of medical care facilities under Title XVIII of Social Security Act.

The Board shall constitute the sole agency of the Commonwealth to enter into contracts with the United States government for the certification of medical care facilities under Title XVIII of the United States Social Security Act and any amendments thereto and with the Virginia Department of Medical Assistance Services for the certification of medical care facilities under Title XIX of the United States Social Security Act and any amendments thereto.

1979, c. 711; 1989, c. 618.

§ 32.1-137.01. Posting of charity care policies.

A. Every hospital shall provide written information about the hospital's charity care policies, including policies related to free and discounted care. Such information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, emergency departments, and associated waiting rooms. Information regarding specific eligibility criteria and procedures for applying for charity care shall also be (i) provided to a patient at the time of admission or discharge, or at the time services are provided; (ii) included with any billing statements sent to uninsured patients; and (iii) included on any website maintained by the hospital.

B. Every hospital that is subject to the requirements of Title VI of the Civil Rights Act of 1964, as amended, shall make the information required by subsection A available to persons with limited English proficiency in accordance with the most recent U.S. Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.

2009, c. 425; 2022, cc. 678, 679.

§ 32.1-137.02. Hospital discharge procedures.

Before a hospital discharges a patient, it shall, to the extent allowed pursuant to state and federal law, inform and educate the patient, and his family when it is involved in decision making or ongoing care, about his follow-up care, treatment, and services.

2012, cc. 180, 813.

§ 32.1-137.03. Discharge planning; designation of individual to provide care.

A. Every hospital (i) shall provide each patient admitted as an inpatient or his legal guardian the opportunity to designate an individual who will care for or assist the patient in his residence following discharge from the hospital and to whom the hospital shall provide information regarding the patient's discharge plan and any follow-up care, treatment, and services that the patient may require and (ii) upon admission, shall record in the patient's medical record the name of the individual designated by

the patient, the relationship between the patient and the person, and the person's telephone number and address. If the patient fails or refuses to designate an individual to receive information regarding his discharge plan and any follow-up care, treatment, and services, the hospital shall record the patient's failure or refusal in the patient's medical record. For the purposes of this subsection, "residence" does not include any rehabilitation facility, hospital, nursing home, assisted living facility, or group home.

B. A patient may change the designated individual at any time prior to the patient's release, and the hospital shall record in the patient's medical record the name of the designated individual, the relationship between the patient and the person, and the person's telephone number and address, within 24 hours of such change.

C. Prior to discharging a patient who has designated an individual pursuant to subsection A or B, the hospital shall notify the designated individual of the patient's discharge and shall provide the designated individual with a copy of the patient's discharge plan and instructions and information regarding any follow-up care, treatment, or services that the designated individual will provide and consult with the designated individual regarding the designated individual's ability to provide the care, treatment, or services. Such discharge plan shall include (i) the name and contact information of the designated individual; (ii) a description of the follow-up care, treatment, and services that the patient requires; and (iii) information, including contact information, about any health care, long-term care, or other community-based services and supports necessary for the implementation of the patient's discharge plan. A copy of the discharge plan and any instructions or information provided to the designated individual shall be included in the patient's medical record.

D. The hospital shall provide each individual designated pursuant to subsection A or B the opportunity for a demonstration of specific follow-up care tasks that the designated individual will provide to the patient in accordance with the patient's discharge plan prior to the patient's discharge, including opportunity for the designated individual to ask questions regarding the performance of follow-up care tasks. Such opportunity shall be provided in a culturally competent manner and in the designated individual's native language.

E. Designation of an individual pursuant to subsection A or B shall not create any obligation on the part of the designated individual regarding the provision of any follow-up care, treatment, and services that the patient may require.

F. Nothing in this section shall create a private right of action against any hospital, its employees, or its contractors.

G. No hospital or its employees or contractors shall be liable for any civil damages for any injuries resulting from any act of an individual designated pursuant to subsection A or B related to the provision of or failure to provide follow-up care, treatment, or services pursuant to a patient's discharge plan.

H. Nothing in this section shall interfere with an individual acting under a valid health care directive.

I. The Department shall promulgate regulations for the implementation of this section.

2015, cc. 18, 106.

§ 32.1-137.04. Patient notice of observation or outpatient status.

A. A hospital shall provide oral and written notice to any patient placed under observation or in any other outpatient status, or to such patient's authorized representative, informing the patient of his placement in such status if (i) the patient receives onsite services from the hospital and (ii) such onsite services include a hospital bed and meals that are provided in an area of the hospital other than the emergency department. Such oral and written notice shall be provided not later than 36 hours after placement under observation or in any other outpatient status unless the patient has been discharged or has left the hospital prior to the expiration of such 36-hour period.

B. Such written notice shall be written in clear, understandable language and printed in at least 14-point type. The written notice shall include:

1. A statement that the patient is not admitted to the hospital as an inpatient but is under observation or in such other outpatient status;

2. A statement that such observation or other outpatient status may affect the patient's Medicare, Medicaid, or private health insurance coverage of (i) the current hospital services, including medications and pharmaceutical supplies, and (ii) care at a skilled nursing facility or home or community-based care upon the patient's discharge from the hospital; and

3. A statement that the patient should contact the identified hospital representative or his health insurance plan for more information on his observation or other outpatient status and any available recourse.

C. For any patient placed under observation or in any other outpatient status who is entitled to have payment made under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), a hospital providing written notice and oral explanation of such notice to the patient which satisfies the provisions of 42 U.S.C. § 1395cc(a)(1)(Y) shall be deemed to have satisfied the provisions of this section.

2015, c. 365; 2018, c. 194.

§ 32.1-137.06. Lyme disease test result information.

A. Every laboratory reporting the results of a test for Lyme disease ordered in an office-based setting by a health care provider shall include a notice to be provided together with such test results when such test results are reported to the health care provider that states: PATIENTS UNDERGOING A LYME DISEASE TEST SHOULD BE AWARE THAT LYME DISEASE TESTS VARY AND MAY PRODUCE RESULTS THAT ARE INACCURATE. THIS MEANS A PATIENT MAY NOT BE ABLE TO RELY ON A POSITIVE OR NEGATIVE RESULT. HEALTH CARE PROVIDERS ARE ENCOURAGED TO DISCUSS LYME DISEASE TEST RESULTS WITH THE PATIENT FOR WHOM THE TEST WAS ORDERED.

B. A laboratory that complies with this section shall be immune from civil liability absent gross negligence or willful misconduct.

2019, c. 435.

§ 32.1-137.07. Violations of certain provisions; penalty.

If the Commissioner receives a report from the State Corporation Commission that a medical care facility has engaged in a pattern of violations pursuant to § 38.2-3445.01 and the report is substantiated after investigation, the Commissioner may levy a fine upon the medical care facility in an amount not to exceed $1,000 per violation and may take other formal or informal disciplinary action as permitted under this chapter.

2020, cc. 1080, 1081.

§ 32.1-137.08. Medical care facilities; persons with disabilities; designated support persons.

A. As used in this section:

"Activity of daily living" means a personal care task such as bathing, dressing, toileting, transferring, and eating or feeding.

"Admission" means (i) with regard to a medical care facility that is a hospital or hospice facility, accepting a person for (a) bed occupancy and care that is anticipated to span at least two midnights or (b) observation and (ii) with regard to a medical care facility that is an outpatient surgical hospital, accepting a person for care, irrespective of anticipated length of care.

"Care provider" means any person or entity responsible for the care of a person with a disability prior to admission of the person with a disability to a medical facility.

"Designated support person" means a person who is 18 years of age or older; knowledgeable about the needs of a person with a disability; and designated, orally or in writing, by the person with a disability or his guardian, authorized representative, or care provider to provide support and assistance necessary due to the specifics of the person's disability to the person with a disability at any time during which health care services are provided.

"Medical care facility" means a hospital licensed pursuant to this article that provides inpatient care, other than a hospital that is certified as a long-term acute care hospital or specialty rehabilitation hospital; an outpatient surgical hospital licensed or certified pursuant to this article; a hospice facility licensed pursuant to Article 7 (§ 32.1-162.1 et seq.); and any institution exempt from licensure pursuant to clause (vi) of § 32.1-124.

"Person with a disability" means a person who, prior to admission to a medical care facility, had a physical, sensory, mental, or emotional impairment that substantially limits one or more activities of daily living or has a record of such impairment.

"Support and assistance necessary due to the specifics of the person's disability" means support and assistance, including assistance with activities of daily living, communication, decision-making, and other supports, that is (i) necessary due to the absence, loss, diminution, or impairment of a physical, sensory, behavioral, cognitive, or emotional function of the person due to the specifics of his disability;

(ii) provided by a designated support person; (iii) ongoing; and (iv) necessary for the care of, and to afford meaningful access to health care for, the person with a disability.

B. Every medical care facility shall allow a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a designated support person who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission. In any case in which the duration of the admission lasts more than 24 hours, the person with a disability may designate more than one designated support person. However, no medical care facility shall be required to allow more than one designated support person to be present with a person with a disability at any time.

C. A designated support person is not a visitor and shall not be subject to any restrictions on visitation adopted by a medical care facility. However, such designated support person may be required to comply with all reasonable requirements of the medical care facility adopted to protect the health and safety of the person with a disability; the designated support person; the staff and other patients of, or visitors to, the medical care facility; and the public. A medical care facility may restrict a designated support person's access to specified areas of and movement on the premises of the medical care facility when such restrictions are determined by the medical care facility to be reasonably necessary to protect the health and safety of the person with a disability; the designated support person; the staff and other patients of, or visitors to, the medical care facility; and the public.

D. A medical care facility may request that a person with a disability provide documentation indicating that he is a person with a disability and, if the person fails, refuses, or is unable to provide such documentation, perform an objective assessment of the person to determine whether he is a person with a disability; however, the failure of a hospital to perform such objective assessment shall not constitute grounds for prohibiting a designated support person from accompanying a person with a disability for the purpose of providing support and assistance necessary due to the specifics of the person's disability.

E. Every medical care facility shall (i) establish protocols to inform patients, at the time of admission, of the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a designated support person for the purpose of providing support and assistance necessary due to the specifics of the person's disability and (ii) develop and make available to a patient, the patient's guardian, the patient's authorized representative, or the person's care provider upon request of the patient, guardian, authorized representative, or care provider written information regarding the right of a person with a disability who requires support and assistance necessary due to the specifics of the person's disability to be accompanied by a designated support person and policies related thereto. Every medical care facility shall also make such written information available to the public on its website.

F. The Department shall develop and make available on its website information for the public regarding (i) the right of a person with a disability who requires support and assistance necessary due to the

specifics of the person's disability to be accompanied by a designated support person who will provide support and assistance necessary due to the specifics of the person's disability to the person with a disability during an admission and (ii) the requirements of this section.

G. Nothing in this section shall alter the obligation of a medical care facility to provide patients with effective communication support or other required services, regardless of the presence of a designated support person or other reasonable accommodation, consistent with applicable federal or state law or regulations.

H. Nothing in this section shall be interpreted to (i) prevent a medical care facility from complying, or interfere with the ability of a medical care facility to comply, with or cause a medical care facility to violate any federal or state law or regulation, (ii) deem a designated support person to be acting under the direction or control of the medical care facility or as an agent of the medical care facility, or (iii) require any medical care facility to allow a designated support person to perform any action or provide any support or assistance necessary due to the specifics of the person's disability when the medical care facility reasonably determines that the performance of such action or provision of such support or assistance necessary due to the specifics of the person's disability would be medically or therapeutically contraindicated or would pose a threat to the health and safety of the person with a disability; the designated support person; or the staff or other patients of, or visitors to, the medical care facility.

2021, Sp. Sess. I, c. 220.

§ 32.1-137.09. Hospital emergency department CPT code data reporting.

A. Every hospital in the Commonwealth that includes an emergency department shall report quarterly to the Department, for the preceding quarter, (i) the total number of visits to the hospital's emergency department, by location, and (ii) the total number of visits to the hospital's emergency department by emergency department evaluation and management (E/M) Physicians' Current Procedural Terminology (CPT) code.

B. The Department shall annually publish a report setting forth the average number of hospital emergency department visits by location and by emergency department E/M CPT code statewide and by region for each month.

C. The Department may enter into a contract or agreement with the nonprofit organization with which the Department has entered into a contract or agreement pursuant to § 32.1-276.4 for the compilation, storage, analysis, and evaluation of data required to be submitted pursuant to this section.

2022, c. 342.

§ 32.1-137.010. Financial assistance; payment plans.

A. As used in this section:

"Patient" means any adult who receives medical services from a hospital or, in the case of a minor who receives medical services from a hospital, the financially responsible party for such minor.

"Uninsured patient" means a patient who does not have any health insurance, third-party assistance, medical savings account, or claims against third parties covered by insurance, is not covered under workers' compensation, a health benefit plan as defined in § 38.2-3438, or an employee welfare benefit plan as defined in § 3(1) of the Employee Retirement Income Security Act of 1974, or does not receive benefits under Title XVIII or XIX of the Social Security Act or 10 U.S.C. § 1071 et seq. or any other form of coverage from private insurance or federal, state, or local government medical assistance programs.

B. Every hospital shall make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for medical assistance pursuant to the state plan for medical assistance or for financial assistance under the hospital's financial assistance policy.

C. Every hospital shall inform every uninsured patient who receives services at the hospital and who is determined to be eligible for assistance under the hospital's financial assistance policy of the option to enter into a payment plan with the hospital. A payment plan entered into pursuant to this subsection shall be provided to the patient in writing or electronically and shall provide for repayment of the cumulative amount owed to the hospital. The amount of monthly payments and the term of the payment plan shall be determined based upon the patient's ability to pay. Any interest on amounts owed pursuant to the payment plan shall not exceed the maximum judgment rate of interest pursuant to § 6.2-302. The hospital shall not charge any fees related to the payment plan. The payment plan shall allow prepayment of amounts owed without penalty.

D. Every hospital shall develop a process by which either an uninsured patient who agrees to a payment plan pursuant to subsection C or the hospital may request and shall be granted the opportunity to renegotiate such payment plan. Such renegotiation shall include opportunity for a new screening in accordance with subdivision B. No hospital shall charge any fees for renegotiation of a payment plan pursuant to this subsection.

E. Notwithstanding any other provision of law, no hospital shall engage in any action described in § 501(r)(6) of the Internal Revenue Code as it was in effect on January 1, 2020, to recover a debt for medical services against any patient unless the hospital has made all reasonable efforts to determine whether the patient qualifies for medical assistance pursuant to the state plan for medical assistance or is eligible for financial assistance under the hospital's financial assistance policy.

F. Every hospital shall include in written information required pursuant to § 32.1-137.01 information about the availability of a payment plan for the payment of debt owed to the hospital pursuant to subsection C and the renegotiation process described in subsection D.

G. Nothing in this section shall be construed to:

1. Prohibit a hospital, as part of its financial assistance policy, from requiring a patient to (i) provide necessary information needed to determine eligibility for financial assistance under the hospital's financial assistance policy, medical assistance pursuant to Title XVIII or XIX of the Social Security Act or 10 U.S.C. § 1071 et seq., or other programs of insurance or (ii) undertake good faith efforts to apply for

and enroll in such programs of insurance for which the patient may be eligible as a condition of awarding financial assistance;

2. Require a hospital to grant or continue to grant any financial assistance or payment plan pursuant to this section when (i) a patient has provided false, inaccurate, or incomplete information required for determining eligibility for such hospital's financial assistance policy or (ii) a patient has not undertaken good faith efforts to comply with any payment plan pursuant to this section; or

3. Prohibit the coordination of benefits as required by state or federal law.

2022, cc. 678, 679.

Article 1.1 - CERTIFICATE OF QUALITY ASSURANCE OF MANAGED CARE HEALTH INSURANCE PLAN LICENSEES

§ 32.1-137.1. Definitions.

As used in this and the following article, unless the context indicates otherwise:

"Agent" or "insurance agent," when used without qualification, means an individual, partnership, limited liability company, or corporation that solicits, negotiates, procures or effects contracts of insurance or annuity in this Commonwealth.

"Bureau of Insurance" means the State Corporation Commission acting pursuant to Title 38.2.

"Complaint" means any written communication from a covered person primarily expressing a grievance.

"Covered person" means an individual residing in the Commonwealth, whether a policyholder, subscriber, enrollee, or member of a managed care health insurance plan, who is entitled to health care services or benefits provided, arranged for, paid for or reimbursed pursuant to a managed care health insurance plan under Title 38.2.

"Managed care health insurance plan" means an arrangement for the delivery of health care in which a health carrier as defined in § 38.2-5800 undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which (i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and (ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. Any health maintenance organization as defined in § 38.2-4300 or health carrier that offers preferred provider contracts or policies as defined in § 38.2-3407 or preferred provider subscription contracts as defined in § 38.2-4209 shall be deemed to be offering one or more managed care health insurance plans. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under

contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple products and multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"Managed care health insurance plan licensee" means a health carrier subject to licensure by the Bureau of Insurance under Title 38.2 who is responsible for a managed care health insurance plan in accordance with Chapter 58 (§ 38.2-5801 et seq.) of Title 38.2.

"Person" means any association, aggregate of individuals, business, company, corporation, individual, joint-stock company, Lloyds type of organization, other organization, partnership, receiver, reciprocal or inter-insurance exchange, trustee or society.

1998, c. 891.

§ 32.1-137.2. Certification of quality assurance; application; issuance; denial; renewal.

A. Every managed care health insurance plan licensee shall request a certificate of quality assurance with reference to its managed care health insurance plans simultaneously with filing an initial application to the Bureau of Insurance for licensure. If already licensed by the Bureau of Insurance, every managed care health insurance plan licensee may file an application for quality assurance certification with the Department of Health by December 1, 1998, and shall file an application for quality assurance certification with the Department of Health by December 1, 1999, in order to obtain its certificate of quality assurance by July 1, 2000.

On or before July 1, 2000, the State Health Commissioner shall certify to the Bureau of Insurance that a managed care health insurance plan licensee has been issued a certificate of quality assurance by providing the Bureau of Insurance with a copy of each certificate at the time of issuance.

Application for a certificate of quality assurance shall be made on a form prescribed by the Board and shall be accompanied by a fee based upon a percentage, not to exceed one-tenth of one percent, of the proportion of direct gross premium income on business done in this Commonwealth attributable to the operation of managed care health insurance plans in the preceding biennium, sufficient to cover reasonable costs for the administration of the quality assurance program. Such fee shall not exceed $10,000 per licensee. Whenever the account of the program shows expenses for the past biennium to be more than 10 percent greater or lesser than the funds collected, the Board shall revise the fees levied by it for certification so that the fees are sufficient, but not excessive, to cover expenses; provided that such fees shall not exceed the limits set forth in this section. Until July 1, 2014, the Department may utilize such certification funds as are needed in fulfilling its responsibilities pursuant to subsection B of § 32.1-16.

All applications, including those for renewal, shall require (i) a description of the geographic area to be served, with a map clearly delineating the boundaries of the service area or areas, (ii) a description of the complaint system required under § 32.1-137.6, (iii) a description of the procedures and programs established by the licensee to assure both availability and accessibility of adequate personnel and

facilities and to assess the quality of health care services provided, and (iv) a list of the licensee's managed care health insurance plans.

B. Every managed care health insurance plan licensee certified under this article shall renew its certificate of quality assurance with the Commissioner biennially by July 1, subject to payment of the fee.

C. The Commissioner shall periodically examine or review each applicant for certificate of quality assurance or for renewal thereof.

No certificate of quality assurance may be issued or renewed unless a managed care health insurance plan licensee has filed a completed application and made payment of a fee pursuant to subsection A and the Commissioner is satisfied, based upon his examination, that, to the extent appropriate for the type of managed care health insurance plan under examination, the managed care health insurance plan licensee has in place and complies with: (i) a complaint system for reasonable and adequate procedures for the timely resolution of written complaints pursuant to § 32.1-137.6; (ii) a reasonable and adequate system for assessing the satisfaction of its covered persons; (iii) a system to provide for reasonable and adequate availability of and accessibility to health care services for its covered persons; (iv) reasonable and adequate policies and procedures to encourage the appropriate provision and use of preventive services for its covered persons; (v) reasonable and adequate standards and procedures for credentialing and recredentialing the providers with whom it contracts; (vi) reasonable and adequate procedures to inform its covered persons and providers of the managed care health insurance plan licensee's policies and procedures; (vii) reasonable and adequate systems to assess, measure, and improve the health status of covered persons, including outcome measures, (viii) reasonable and adequate policies and procedures to ensure confidentiality of medical records and patient information to permit effective and confidential patient care and quality review; (ix) reasonable, timely and adequate requirements and standards pursuant to § 32.1-137.9; and (x) such other requirements as the Board may establish by regulation consistent with this article.

Upon the issuance or reissuance of a certificate, the Commissioner shall provide a copy of such certificate to the Bureau of Insurance.

D. Upon determining to deny a certificate, the Commissioner shall notify such applicant in writing stating the reasons for the denial of a certificate. A copy of such notification of denial shall be provided to the Bureau of Insurance. Appeals from a notification of denial shall be brought by a certificate applicant pursuant to the process set forth in § 32.1-137.5.

E. The State Corporation Commission shall give notice to the Commissioner of its intention to issue an order based upon a finding of insolvency, hazardous financial condition, or impairment of net worth or surplus to policyholders or an order suspending or revoking the license of a managed care health insurance plan licensee; and the Commissioner shall notify the Bureau of Insurance when he has reasonable cause to believe that a recommendation for the suspension or revocation of a certificate of quality assurance or the denial or nonrenewal of such a certificate may be made pursuant to this article. Such notifications shall be privileged and confidential and shall not be subject to subpoena.

F. No certificate of quality assurance issued pursuant to this article may be transferred or assigned without approval of the Commissioner.

G. When determining the adequacy of a managed care health insurance plan proposed provider network or the ongoing adequacy of an in-force provider network, the Commissioner shall consider whether the managed care health insurance plan proposed provider network or in-force provider network includes a sufficient number of contracted providers of emergency services and surgical or ancillary services, as those terms are defined in § 38.2-3438, at or for the managed care health insurance plan's contracted in-network hospitals to reasonably ensure that enrollees have in-network access to covered benefits delivered at that facility.

1998, c. 891; 2013, cc. 670, 679; 2020, cc. 1080, 1081.

§ 32.1-137.3. Regulations.

Consistent with its duties to protect the health, safety, and welfare of the public, the Board shall promulgate regulations, consistent with this article, governing the quality of care provided to covered persons by a managed care health insurance plan licensee through its managed care health insurance plans on or before December 1, 1999. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist and as appropriate for the type of managed care health insurance plan. The regulations shall also include guidelines for the Commissioner to determine, in consultation with the Bureau of Insurance, when the imposition of administrative sanctions as set forth in § 32.1-137.5 or initiation of court proceedings or both are appropriate in order to ensure prompt correction of violations discovered on any examination, review, or investigation conducted by the Department pursuant to provisions of this article.

1998, c. 891.

§ 32.1-137.4. Examination, review or investigation.

A. The Commissioner shall cause each managed care health insurance plan licensee subject to certification under this article to be examined or reviewed for each new application and to be periodically examined or reviewed at reasonable times thereafter, including both for complaint investigation and for renewal compliance. Such examinations or reviews shall consider the compliance of the managed care health insurance plan licensee with the regulations promulgated under § 32.1-137.3.

In lieu of or in addition to making his own examination of the managed care health insurance plan licensee, the Commissioner may accept the report of an examination of the licensee under similar laws of another state, similar regulatory agency, state health commissioner, or accreditation entity.

B. Any examiner authorized by the Commissioner shall, so far as necessary for the purposes of the examination or review, have access during regular business hours to the premises and to any books, records, files, or property of the licensee as far as they directly relate to the quality of care provided by the licensee. All material copied or recorded or received shall be privileged and confidential and shall not be subject to subpoena.

C. Every person from whom information is sought, in an investigation of a complaint pursuant to this article against a managed care health insurance plan licensee, shall cooperate in producing or allowing reasonable access during regular business hours to the books, records, files, accounts, papers, documents, and any or all computer or other recordings of the licensee being examined or those of any person delivering health care services under contract, affiliation, delegation or other arrangement directly relevant to the investigation. Such information shall be limited to that which is relevant to the investigation in question, as specified in regulations promulgated pursuant to this article. All material copied or recorded or received shall be privileged and confidential, and shall not be subject to subpoena.

D. The refusal of any licensee, by its officers, directors, employees or agents, to submit to examination or review or to comply with any reasonable written request of the examiners shall be grounds for suspension, revocation, denial, or nonrenewal of any certificate of quality assurance held by the licensee. Any such proceedings for suspension, revocation, denial or nonrenewal of any certificate shall be conducted pursuant to § 32.1-137.5.

1998, c. 891.

Article 1 - Hospital and Nursing Home Licensure and Inspection

§ 32.1-137.05. Regulations.

A. Every hospital shall make available to the public on its website a machine-readable file containing a list of all standard charges for all items and services provided by the hospital in accordance with 45 C.F.R. § 180.50, as amended. As used in this subsection, “hospital,” “items and services,” “machine-readable,” and “standard charge” have the same meaning as set forth in 45 C.F.R. § 180.20.

B. Every hospital shall, upon request of a patient scheduled to receive an elective procedure, test, or service to be performed by the hospital, or upon request of such patient’s legally authorized representative, made no less than three days in advance of the date on which such elective procedure, test, or service is scheduled to be performed, furnish the patient with an estimate of the payment amount for which the participant will be responsible for such elective procedure, test, or service. Every hospital shall provide written information about the patient’s ability to request an estimate of the payment amount pursuant to this section. Such written information shall be posted conspicuously in public areas of the hospital, including admissions or registration areas, and included on any website maintained by the hospital.

2016, c. 448; 2019, cc. 670, 671; 2022, c. 297.

Article 1.1 - CERTIFICATE OF QUALITY ASSURANCE OF MANAGED CARE HEALTH INSURANCE PLAN LICENSEES

§ 32.1-137.5. Civil penalties; probation; suspension; restriction or prohibition of new enrollments to managed care health insurance plan licensee; revocation or nonrenewal of certificate of quality assurance; appeal process; correction.

A. In accordance with applicable regulations of the Board and in consultation with the Bureau of Insurance, the Commissioner (i) may impose civil penalties, which shall not exceed $1,000 per incident of noncompliance, to a maximum of $10,000 for a series of related incidents of noncompliance, (ii) may place a certificate holder on probation, (iii) may temporarily suspend a certificate of quality assurance of a managed care health insurance plan licensee, (iv) may, with the concurrence of the Bureau of Insurance, temporarily restrict or prohibit new enrollments into a managed care health insurance plan, or (v) may revoke or not renew a certificate of quality assurance and certify to the State Corporation Commission that a managed care health insurance plan licensee or its managed care health insurance plan is unable to fulfill its obligations to furnish quality health care services as set forth in this article. Fines payable under this section shall be paid into the Literary Fund.

B. When examination or review or complaint investigation by the Department results in a finding of noncompliance with the provisions of this article or the regulations of the Board, the managed care health insurance plan licensee or applicant shall be provided written notice and a report specifying the findings of noncompliance and providing an opportunity to be heard in no fewer than thirty days by the Commissioner's adjudication officer in a proceeding under § 2.2-4019. A copy of the notice and report shall be provided to the Bureau of Insurance. Such proceeding shall be separate from the regulatory office of the Department that conducted the examination, review, or investigation and shall be closed and confidential. The records of the proceedings shall be privileged and confidential and shall not be subject to subpoena.

The adjudication officer shall provide a recommendation to the Commissioner, including findings of fact, conclusions, and appropriate disciplinary action or sanction. The Commissioner shall promptly notify the Bureau of Insurance if the recommended disciplinary action or sanction proposes probation, suspension, nonrenewal, or revocation of a certificate of quality assurance, or the temporary restriction or prohibition of new enrollments in a managed care health insurance plan. The Commissioner may affirm, modify, or reverse such recommendation and shall issue a final decision.

The Commissioner's decision may be appealed directly to a circuit court under Article 4 (§ 2.2-4025 et seq.) of the Administrative Process Act. The only parties to the case shall be the managed care health insurance plan licensee and the Department. The Commissioner shall promptly notify the Bureau of Insurance of the commencement and final determination of an appeals proceeding.

C. If a certificate of quality assurance has been revoked or suspended or a certificate holder has been placed on probation, a new certificate may be issued or the suspension may be terminated or the probation removed by the Commissioner after satisfactory evidence is submitted to him that the conditions upon which revocation, suspension, or probation was based have been corrected and after proper examination has been made and compliance with all provisions of this article and the regulations of the Board has been shown.

1998, c. 891.

§ 32.1-137.6. Complaint system.

A. Each managed care health insurance plan licensee subject to § 32.1-137.2 shall establish and maintain for each of its managed care health insurance plans a complaint system approved by the Commissioner and the Bureau of Insurance to provide reasonable procedures for the resolution of written complaints in accordance with the requirements established under this article and Title 38.2, and shall include the following:

1. A record of the complaints shall be maintained for the period set forth in § 32.1-137.16 for review by the Commissioner.

2. Each managed care health insurance plan licensee shall provide complaint forms and/or written procedures to be given to covered persons who wish to register written complaints. Such forms or procedures shall include the address and telephone number of the managed care licensee to which complaints shall be directed and the mailing address, telephone number, and the electronic mail address of the Office of the Managed Care Ombudsman established pursuant to § 38.2-5904 and shall also specify any required limits imposed by or on behalf of the managed care health insurance plan. Such forms and written procedures shall include a clear and understandable description of the covered person's right to appeal adverse determinations pursuant to § 32.1-137.15.

B. The Commissioner, in cooperation with the Bureau of Insurance, shall examine the complaint system. The effectiveness of the complaint system of the managed care health insurance plan licensee in allowing covered persons, or their duly authorized representatives, to have issues regarding quality of care appropriately resolved under this article shall be assessed by the State Health Commissioner under this article. Compliance by the health carrier and its managed care health insurance plans with the terms and procedures of the complaint system, as well as the provisions of Title 38.2, shall be assessed by the Bureau of Insurance.

C. As part of the renewal of a certificate, each managed care health insurance plan licensee shall submit to the Commissioner and to the Office of the Managed Care Ombudsman an annual complaint report in a form agreed and prescribed by the Board and the Bureau of Insurance. The complaint report shall include, but shall not be limited to (i) a description of the procedures of the complaint system, (ii) the total number of complaints handled through the complaint system, (iii) the disposition of the complaints, (iv) a compilation of the nature and causes underlying the complaints filed, (v) the time it took to process and resolve each complaint, and (vi) the number, amount, and disposition of malpractice claims adjudicated during the year with respect to any of the managed care health insurance plan's health care providers.

The Department of Human Resource Management and the Department of Medical Assistance Services shall file similar periodic reports with the Commissioner, in a form prescribed by the Board, providing appropriate information on all complaints received concerning quality of care and utilization review under their respective health benefits program and managed care health insurance plan licensee contractors.

D. The Commissioner shall examine the complaint system under subsection B for compliance of the complaint system with respect to quality of care and shall require corrections or modifications as deemed necessary.

E. The Commissioner shall have no jurisdiction to adjudicate individual controversies arising under this article.

F. The Commissioner of Health or the nonprofit organization pursuant to § 32.1-276.4 may prepare a summary of the information submitted pursuant to this provision and § 32.1-122.10:01 to be included in the patient level data base.

1998, cc. 744, 891; 1999, cc. 643, 649; 2000, cc. 66, 657, 922; 2011, c. 788.

Article 1.2 - UTILIZATION REVIEW STANDARDS AND APPEALS

§ 32.1-137.7. Definitions.

As used in this article:

"Adverse determination" means a determination by the managed care health insurance plan or its designee utilization review entity that, based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit. When the policy, contract, plan, certificate, or evidence of coverage includes coverage for prescription drugs and the health service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse determination shall be made within 24 hours of the request for coverage.

"Commission" means the Virginia State Corporation Commission.

"Covered person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Evidence of coverage" includes any certificate, individual or group agreement or contract, or identification card or related documents issued in conjunction with the certificate, agreement or contract, issued to a subscriber setting out the coverage and other rights to which a covered person is entitled.

"Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a managed care health insurance plan, or its designee utilization review entity, at the completion of the managed care health insurance plan's internal appeal process.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review entity responsible for compliance with the provisions of this article.

"Peer of the treating health care provider" means a physician or other health care professional who holds a nonrestricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or

2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Treating health care provider" or "provider" means a licensed health care provider who renders or proposes to render health care services to a covered person.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132, and 38.2-134.

"Utilization review entity" or "entity" means a person or entity performing utilization review.

"Utilization review plan" or "plan" means a written procedure for performing review.

1998, cc. 129, 891; 1999, c. 857; 2000, c. 564; 2011, c. 788.

§ 32.1-137.8. Application to and compliance by utilization review entities.

A. No utilization review entity shall perform utilization review with regard to hospital, medical or other health care resources rendered or proposed to be rendered to a covered person except in accordance with the requirements and standards set forth in this article.

B. This article shall not apply to utilization review performed under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974.

C. This article shall not apply to private review agents subject to Article 2.1 (§ 32.1-138.6 et seq.) of Chapter 5 of Title 32.1 of the Code of Virginia.

D. This article shall not apply to programs administered by the Department of Medical Assistance Services or under contract with the Department of Medical Assistance Services.

1998, cc. 129, 891.

§ 32.1-137.9. Requirements and standards for utilization review entities.

A. Each entity shall establish reasonable and prudent standards and criteria to be applied in utilization review determinations with input from physician advisors representing major areas of specialty and certified by the boards of the various American medical specialties. Such standards shall be objective, clinically valid, and compatible with established principles of health care. Such standards shall further be established so as to be sufficiently flexible to allow deviations from norms when justified on case-by-case bases.

The entity shall make available to any provider or covered person, upon written request, a list of such physician advisors and their major areas of specialty, as well as the standards and criteria established in accordance with this section except as prohibited in accordance with copyright laws.

B. An adverse determination shall be made only in accordance with § 32.1-137.13.

C. Each entity shall have a process for reconsideration of an adverse determination in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15.

D. Each entity shall make arrangements to use the services of physician advisors who are specialists in the various categories of health care on "per need" or "as needed" bases in conducting utilization review.

E. Each entity shall have review staff who are properly qualified, trained and supervised, and supported by a physician advisor, to carry out its review determinations.

F. Each entity shall notify its covered persons of the review process, including the appeals process, and shall so notify the covered person's provider upon written request by the provider. An Evidence of Coverage shall contain a clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of the process for reconsideration of an adverse determination rendered under §

32.1-137.13, as required by § 32.1-137.14, and the process for internal appeal from an adverse determination under § 32.1-137.15.

G. Each entity shall communicate its utilization review decision no later than two business days after receipt by the entity of all information necessary to complete the review.

H. Each entity shall have a representative, authorized to approve utilization review determinations, available to covered persons and providers in accordance with § 32.1-137.11.

I. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity establish reasonable and prudent requirements and standards pursuant to this section.

1998, c. 891; 2011, c. 788.

§ 32.1-137.10. Utilization review plan required.

A. Each utilization review entity subject to this article shall adopt a utilization review plan that contains procedures for complying with the requirements and standards of § 32.1-137.9 and other applicable provisions of this article. Such plan shall contain, at a minimum, the following:

1. Specific procedures to be used in review determinations, including an expedited review of no more than twenty-four hours for review determinations relating to prescriptions for the alleviation of cancer pain;

2. A provision for advance notice to covered persons of any requirements for certification of the health care setting or pre-approval of the necessity of health care service or any other prerequisites to approval of payment;

3. A provision for advance notice to covered persons that compliance with the review process is not a guarantee of benefits or payment under the health benefit plan;

4. A provision for a process for reconsideration of adverse decisions in accordance with § 32.1-137.14 and an appeals process in accordance with § 32.1-137.15; and

5. Policies and procedures designed to ensure confidentiality of patient-specific medical records and information in accordance with subsection C of § 32.1-137.12.

B. Each utilization review entity subject to this chapter shall make available to providers and covered persons, upon written request, a copy of those portions of its utilization review plan relevant to the specific request.

C. The Commissioner shall have the right to determine that an entity has complied with the requirement that the entity adopt a utilization review plan in accordance with subsection A.

1998, c. 891; 1999, c. 857.

§ 32.1-137.11. Accessibility of utilization review entity.

A utilization review entity shall provide accessibility for covered persons and providers by free telephone at least forty hours per week during normal business hours. Entities located outside of the eastern time zone shall provide covered persons advance written notification of the eastern time zone

hours during which those entities are accessible; however, such hours shall be no less than forty hours per week during normal business hours. The entity shall install and maintain an adequate telephone system that accepts and records messages or accepts and provides recorded business hour information for incoming calls outside of normal business hours.

1998, c. 891.

§ 32.1-137.12. Emergencies; extensions; access to and confidentiality of patient-specific medical records and information.

A. For emergency health care, authorization may be requested by the covered person, his representative, or his provider either within forty-eight hours of or by the end of the first business day following the rendering of the emergency health care, whichever is later.

B. An entity shall promptly review a request from the covered person, his representative, or his provider for an extension of the original approved duration of health care or hospitalization. If the entity fails to confirm that termination of health care or hospitalization will occur on the original date authorized, the entity shall review retrospectively whether the extension of health care or hospitalization was medically appropriate.

C. Each entity shall have reasonable access to patient-specific medical records and information.

1998, c. 891.

§ 32.1-137.13. Adverse determination.

A. The treating provider shall be notified in writing of any adverse determination within two working days of the determination; however, the treating provider shall be notified orally by telephone within 24 hours of any adverse determination for a prescription known to be for the alleviation of cancer pain. Any such notification shall include instructions for the provider on behalf of the covered person to (i) seek a reconsideration of the adverse determination pursuant to § 32.1-137.14, including the contact name, address, and telephone number of the person responsible for making the adverse determination, and (ii) seek an appeal of the adverse determination pursuant to § 32.1-137.15, including the contact name, address, and telephone number to file and perfect such appeal.

B. No entity shall render an adverse determination unless it has made a good faith attempt to obtain information from the provider. At any time before the entity renders its determination, the provider shall be entitled to review the issue of medical necessity with a physician advisor or peer of the treating health care provider who represents the entity. For any adverse determination relating to a prescription to alleviate cancer pain, a physician advisor shall review the issue of medical necessity with the provider.

1998, c. 891; 1999, c. 857; 2001, c. 22; 2010, c. 395; 2011, c. 788.

§ 32.1-137.14. Reconsideration of adverse determination.

A. A treating provider may request reconsideration of an adverse determination pursuant to this section or may appeal an adverse determination pursuant to § 32.1-137.15. Any reconsideration of an

adverse determination shall only be requested by the treating provider on behalf of the covered person. A determination on reconsideration shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel.

B. The treating provider on behalf of the covered person shall be (i) notified verbally at the time of the determination of the reconsideration of the adverse determination and in writing following the determination of the reconsideration of the adverse determination, in accordance with § 32.1-137.9, including the criteria used and the clinical reason for the adverse determination and the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and (ii) notified verbally at the time of the determination of the reconsideration of the adverse determination of the process for an appeal of the determination pursuant to § 32.1-137.15 and the contact name, address, and telephone number to file and perfect an appeal. If the treating provider on behalf of the covered person requests that the adverse determination be reviewed by a peer of the treating provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal pursuant to § 32.1-137.15. In such cases, the covered person shall be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during the reconsideration process pursuant to this section shall be converted to the appeal process, and no additional actions shall be required of the treating provider to perfect the appeal.

C. Any reconsideration shall be rendered and the determination provided to the treating provider and the covered person in writing within 10 working days of receipt of the request for reconsideration.

1998, c. 891; 2010, c. 395; 2011, c. 788.

§ 32.1-137.15. Adverse determination; appeal.

Each entity shall establish an internal appeals process, including a process for urgent care appeals, to consider any adverse determination that is appealed by a covered person, his representative, or his provider in accordance with the provisions of § 38.2-3558.

1998, c. 891; 1999, cc. 643, 649, 857; 2000, c. 922; 2010, c. 395; 2011, c. 788.

§ 32.1-137.16. Records.

Every entity subject to Article 1.1 (§ 32.1-137.1 et seq.) of Chapter 5 and this article shall maintain or cause to be maintained, in writing and at a location accessible to employees of the Department, records of review procedures; the health care qualifications of the entity's staff; the criteria used by the entity to make its determinations; records of complaints received, including the manner in which the complaints were resolved; the number and type of adverse determinations and reconsiderations; the number and outcome of final adverse determinations and appeals thereof, including a separate record for expedited appeals; and procedures to ensure confidentiality of medical records and personal information. Records of complaints under Article 1.1 (§ 32.1-137.1 et seq.) shall be maintained from the date of the entity's last examination and for no less than six years.

Every entity subject to utilization review under this article shall provide, upon request of the Commissioner, data and records pertaining to utilization review from which patient and provider identifiers have been removed. Records shall be maintained or caused to be maintained by the utilization review entity for a period of six years, and all such records shall be subject to examination by the Commissioner or his designee.

1998, c. 891; 2011, c. 788.

§ 32.1-137.17. Limitation on Commissioner's jurisdiction.

The Commissioner shall have the right to determine compliance with this article; however, the Commissioner shall have no jurisdiction to adjudicate individual controversies arising out of or incidental to this article.

1998, c. 891.

Article 2 - Rights and Responsibilities of Patients in Nursing Homes

§ 32.1-138. Enumeration; posting of policies; staff training; responsibilities devolving on guardians, etc.; exceptions; certification of compliance.

A. The governing body of a nursing home facility required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter, through the administrator of such facility, shall cause to be promulgated policies and procedures to ensure that, at the minimum, each patient admitted to such facility:

1. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during his stay, of his rights and of all rules and regulations governing patient conduct and responsibilities;

2. Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during his stay, of services available in the facility, the terms of such services, and related charges, including any charges for services not covered under Titles XVIII or XIX of the United States Social Security Act or not covered by the facility's basic per diem rate;

3. Is fully informed in summary form of the findings concerning the facility in federal Centers for Medicare & Medicaid Services surveys and investigations, if any;

4. Is fully informed by a physician, a physician assistant, or an advanced practice registered nurse of his medical condition unless medically contraindicated as documented by a physician, a physician assistant, or an advanced practice registered nurse in his medical record and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

5. Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act, and is given reasonable advance notice as provided in § 32.1-138.1 to ensure orderly transfer or discharge, and such actions are documented in his medical record;

6. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient and as a citizen and to this end may voice grievances and recommend changes in policies and services to facility staff and to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

7. May manage his personal financial affairs, or may have access to records of financial transactions made on his behalf at least once a month and is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with state law;

8. Is free from mental and physical abuse and free from chemical and, except in emergencies, physical restraints except as authorized in writing by a physician for a specified and limited period of time or when necessary to protect the patient from injury to himself or to others;

9. Is assured confidential treatment of his personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of his transfer to another health care institution or as required by law or third-party payment contract;

10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. May associate and communicate privately with persons of his choice and send and receive his personal mail unopened, unless medically contraindicated as documented by his physician in his medical record;

13. May meet with and participate in activities of social, religious and community groups at his discretion, unless medically contraindicated as documented by his physician, physician assistant, or advanced practice registered nurse in his medical record;

14. May retain and use his personal clothing and possessions as space permits unless to do so would infringe upon rights of other patients and unless medically contraindicated as documented by his physician, physician assistant, or advanced practice registered nurse in his medical record;

15. If married, is assured privacy for visits by his or her spouse and if both are inpatients in the facility, is permitted to share a room with such spouse unless medically contraindicated as documented by the attending physician, physician assistant, or advanced practice registered nurse in the medical record; and

16. Is fully informed, as evidenced by the written acknowledgment of the resident or his legal representative, prior to or at the time of admission and during his stay, that he should exercise whatever due diligence he deems necessary with respect to information on any sexual offenders registered pursuant to Chapter 9 (§ 9.1-900 et seq.) of Title 9.1, including how to obtain such information. Upon request, the nursing home facility shall assist the resident, prospective resident, or the legal

representative of the resident or prospective resident in accessing this information and provide the resident, prospective resident, or the legal representative of the resident or prospective resident with printed copies of the requested information.

B. All established policies and procedures regarding the rights and responsibilities of patients shall be printed in at least 12-point type and posted conspicuously in a public place in all nursing home facilities required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter. These policies and procedures shall include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to patients upon admittance to the facility and made available to patients currently in residence, to any guardians, responsible party as defined in regulation, next of kin, or sponsoring agency or agencies, and to the public.

C. The provisions of this section shall not be construed to restrict any right that any patient in residence has under law.

D. Each facility shall provide appropriate staff training to implement each patient's rights included in subsection A hereof.

E. All rights and responsibilities specified in subsection A hereof and § 32.1-138.1 as they pertain to (i) a patient adjudicated incapacitated in accordance with state law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who is unable to communicate with others shall devolve to such patient's guardian, responsible party as defined in regulation, next of kin, sponsoring agency or agencies, or representative payee, except when the facility itself is representative payee, selected pursuant to section 205(j) of Title II of the United States Social Security Act. The persons to whom such rights and responsibilities have devolved shall be deemed to have legal authority to act on the patient's behalf with respect to the matters specified in this section.

F. Nothing in this section shall be construed to prescribe, regulate, or control the remedial care and treatment or nursing service provided to any patient in a nursing institution to which the provisions of § 32.1-128 are applicable.

G. It shall be the responsibility of the Commissioner to insure that the provisions of this section and the provisions of § 32.1-138.1 are observed and implemented by nursing home facilities. Each nursing home facility to which this section and § 32.1-138.1 are applicable shall certify to the Commissioner that it is in compliance with the provisions of this section and the provisions of § 32.1-138.1 as a condition to the issuance or renewal of the license required by Article 1 (§ 32.1-123 et seq.) of this chapter.

Code 1950, § 32-296.1; 1976, c. 349; 1979, c. 711; 1987, c. 221; 1997, c. 801; 1999, c. 783; 2000, c. 177; 2004, c. 855; 2006, c. 396; 2007, cc. 120, 163; 2010, c. 57; 2023, c. 183.

§ 32.1-138.1. Implementation of transfer and discharge policies.

A. To implement and conform with the provisions of subdivision A 4 of § 32.1-138, a facility may discharge the patient, or transfer the patient, including transfer within the facility, only:

1. If appropriate to meet that patient's documented medical needs;

2. If appropriate to safeguard that patient or one or more other patients from physical or emotional injury;

3. On account of nonpayment for his stay except as prohibited by Titles XVIII or XIX of the United States Social Security Act and the Virginia State Plan for Medical Assistance Services; or

4. With the informed voluntary consent of the patient, or if incapable of providing consent, with the informed voluntary consent of the patient's authorized decision maker pursuant to § 54.1-2986 acting in the best interest of the patient, following reasonable advance written notice.

B. Except in an emergency involving the patient's health or well being, no patient shall be transferred or discharged without prior consultation with the patient, the patient's family or responsible party and the patient's attending physician. If the patient's attending physician is unavailable, the facility's medical director in conjunction with the nursing director, social worker or another health professional, shall be consulted. In the case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the facility shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge.

C. Except in an emergency involving the patient's health or well being, reasonable advance written notice shall be given in the following manner. In the case of a voluntary transfer or discharge, notice shall be reasonable under the circumstances. In the case of an involuntary transfer or discharge, reasonable advance written notice shall be given to the patient at least five days prior to the discharge or transfer.

D. Nothing in this section or in subdivision A 4 of § 32.1-138 shall be construed to authorize or require conditions upon a transfer within a facility that are more restrictive than Titles XVIII or XIX of the United States Social Security Act or by regulations promulgated pursuant to either title.

1987, c. 221; 1993, c. 692.

§ 32.1-138.2. Certain contract provisions prohibited.

No contract or agreement for nursing home care shall contain any provisions which restrict or limit the ability of a resident to apply for and receive Medicaid or which require a specified period of residency prior to applying for Medicaid. The resident may be required to notify the facility when an application for Medicaid has been made. No contract or agreement may require a deposit or other prepayment from Medicaid recipients. No contract or agreement shall contain provisions authorizing the facility to refuse to accept retroactive Medicaid benefits.

1987, c. 221.

§ 32.1-138.3. Third party guarantor prohibition.

Any facility certified under Title XVIII or XIX of the United States Social Security Act shall not require a third party guarantee of payment to the facility as a condition of admission or of expedited admission to, or continued stay in, the facility. This section shall not be construed to prevent a facility from requiring an individual who has legal access to a resident's income or resources which are available to pay for care in the facility to sign a contract without incurring personal financial liability except for breach of the duty to provide payment from the resident's income or resources for such care.

For purposes of this section, the resident's income or resources shall include any amount deemed to be income or resources of the resident for purposes of Medicaid eligibility and any resources transferred by the resident to a third party if the transfer disqualifies the resident from Medicaid coverage for nursing facility services.

1989, c. 193.

§ 32.1-138.4. Retaliation or discrimination against complainants.

No nursing facility may retaliate or discriminate in any manner against any person who (i) in good faith complains or provides information to, or otherwise cooperates with, the Department or any other agency of government or any person or entity operating under contract with an agency of government, having responsibility for protecting the rights of patients of nursing facilities or (ii) attempts to assert any right protected by state or federal law.

1994, c. 941.

§ 32.1-138.5. Confidentiality of complainant's identity.

Whenever the Department conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint, or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Identities of the complainant and patient who is the subject of the complaint shall be revealed only if a court order so requires. Nothing contained herein shall prevent the Department, in its discretion, from disclosing to the nursing facility the nature of the complaint or the identity of the patient who is the subject of the complaint. Nothing contained herein shall prevent the Department or its employees from making reports under § 63.2-1603 et seq. If the Department intends to rely, in whole or in part, on any statements made by the complainant, at any administrative hearing brought against the nursing facility, the Department shall disclose the identity of the complainant to the nursing facility a reasonable time in advance of such hearing.

1994, c. 941.

Article 2.1 - PRIVATE REVIEW AGENTS

§ 32.1-138.6. Definitions.

In this chapter the following terms have the meanings indicated:

"Certificate of registration" means a certificate of registration granted by the Department of Health to a private review agent.

"Medical director" means a physician licensed to practice medicine in the Commonwealth of Virginia who is an employee of a utilization review organization responsible for compliance with the provisions of this article.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a utilization review entity in connection with its utilization review activities.

"Private review agent" means a person or entity performing utilization reviews, except that the term shall not include the following entities or employees of any such entity so long as they conduct utilization reviews solely for subscribers, policyholders, members or enrollees:

1. A health maintenance organization authorized to transact business in Virginia; or

2. A health insurer, hospital service corporation, health services plan or preferred provider organization authorized to offer health benefits in this Commonwealth.

"Utilization review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care resources rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, health maintenance organization, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include (i) any review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117, 38.2-118, 38.2-119, 38.2-124, 38.2-125, 38.2-126, 38.2-130, 38.2-131, 38.2-132 and 38.2-134.

"Utilization review program" means a program for conducting utilization reviews by a private review agent.

1990, c. 826, § 38.2-5300; 1995, c. 745; 1996, c. 259; 1998, c. 129; 2000, c. 564.

§ 32.1-138.7. Certificates of registration required; issuance; transferability; regulations.

A private review agent may not conduct utilization reviews in the Commonwealth unless the Department has granted the private review agent a certificate of registration. The Department shall issue a certificate of registration to an applicant that has met the minimum standards required by this article

and applicable regulations of the Department. A certificate of registration issued under this article is not transferable.

1990, c. 826, § 38.2-5301; 1998, c. 129.

§ 32.1-138.8. Consultation with health regulatory boards.

If in the administration of this article a question concerning compliance with standards of practice governing any health care profession arises pursuant to Subtitle III (§ 54.1-2400 et seq.) of Title 54.1, the Commissioner or his designee shall consult with the appropriate health regulatory board within the Department of Health Professions.

1998, c. 129.

§ 32.1-138.9. Standards for approval.

Each private review agent shall file an application with the Department which shall meet the following minimum standards and any additional standards established by regulation pursuant to § 32.1-138.15, and pay a filing fee established by the Department, in order to be approved by the Department:

1. A description of the procedures to be used in evaluating proposed or delivered hospital, medical, or other health care services;

2. The procedures by which patients or providers may seek reconsideration of determinations by private review agents;

3. The type and qualifications of the personnel either employed or under contract to perform the utilization review;

4. Procedures and policies which ensure that patient-specific medical records and information shall be kept strictly confidential except as authorized by the patient or by regulations adopted pursuant to this article; and

5. Assurances that reviewers be readily accessible by telephone to patients and providers at least forty hours per week during normal business hours.

1990, c. 826, § 38.2-5302; 1998, c. 129.

§ 32.1-138.10. Expiration; renewal.

Each certificate of registration shall expire on the second anniversary of its effective date unless the certificate of registration is renewed for a two-year term as provided in this section. The Department shall renew the certificate of registration for an additional two-year term if the applicant is otherwise entitled to the certificate of registration, pays to the Department the renewal fee set by regulations, submits to the Department a renewal application on a form prescribed by the Department, submits satisfactory assurances of compliance with the requirements of this article and updates information on file with the Department pursuant to this section.

1990, c. 826, § 38.2-5303; 1998, c. 129.

§ 32.1-138.11. Denial; revocation.

A. The Department may deny a certificate of registration to any applicant if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this article or by any regulations promulgated pursuant to this article.

B. The Department may revoke a certificate of registration, or place the holder on probation with terms and conditions, if the holder demonstrates that it is unable or unwilling to meet the requirements of this chapter or of regulations adopted pursuant to this article.

1990, c. 826, § 38.2-5304; 1998, c. 129.

§ 32.1-138.12. Waiver of requirements of article.

The Department shall waive the requirements of this article for a private review agent that operates under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act or under contract with a plan otherwise exempt from operation of this chapter pursuant to the Employee Retirement Income Security Act of 1974.

1990, c. 826, § 38.2-5306; 1998, c. 129.

§ 32.1-138.13. Access to and confidentiality of patient-specific medical records and information.

Private review agents who have been granted a certificate of registration by the Department shall have reasonable access to patient-specific medical records and information to the extent and in the manner authorized by regulation.

1990, c. 826, § 38.2-5307; 1998, c. 129.

§ 32.1-138.14. No private right of action created.

This article shall not be construed to create a private right of action against a private review agent on behalf of a subscriber, policyholder, member, enrollee or other person.

1990, c. 826, § 38.2-5308; 1998, c. 129.

§ 32.1-138.15. Regulations.

The Department shall promulgate regulations, pursuant to the Administrative Process Act (§ 2.2-4000 et seq.), to implement the provisions of this article, which shall include, but not be limited to, the following items:

1. Minimum qualifications to perform review;

2. Procedures which require the private review agent to provide the attending physician an opportunity to consult with a physician advisor prior to issuance of a final denial in any case in which there is an initial recommendation to deny coverage;

3. Guidelines regarding access to and confidentiality of patient-specific medical records and information; and

4. Setting the amount of any fees required by this article, which shall be sufficient to pay for the administrative costs of regulation under this article.

1990, c. 826, § 38.2-5309; 1998, c. 129.

Article 3 - BLOOD BANKS

§§ 32.1-139 through 32.1-144. Repealed.

Repealed by Acts 1993, c. 203.

Article 4 - MIDWIVES

§§ 32.1-145 through 32.1-147. Repealed.

Repealed by Acts 2003, c. 641, cl. 2.

Article 5 - EMERGENCY MEDICAL SERVICE VEHICLES

§§ 32.1-148 through 32.1-156. Repealed.

Repealed by Acts 1996, c. 899.

Article 6 - HOME HEALTH AGENCY LICENSING

§§ 32.1-157 through 32.1-162. Repealed.

Repealed by Acts 1984, c. 497.

Article 7 - Hospice Program Licensing

§ 32.1-162.1. Definitions.

As used in this article unless a different meaning or construction is clearly required by the context or otherwise:

"Hospice" means a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. A hospice utilizes a medically directed interdisciplinary team. A hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care shall be available twenty-four hours a day, seven days a week.

"Hospice facility" means an institution, place, or building owned or operated by a hospice provider and licensed by the Department to provide room, board, and appropriate hospice care on a 24-hour basis, including respite and symptom management, to individuals requiring such care pursuant to the orders of a physician. Such facilities with 16 or fewer beds are exempt from Certificate of Public Need laws and regulations. Such facilities with more than 16 beds shall be licensed as a nursing facility or hospital and shall be subject to Certificate of Public Need laws and regulations.

"Hospice patient" means a diagnosed terminally ill patient, with an anticipated life expectancy of six months or less, who, alone or in conjunction with designated family members, has voluntarily requested admission and been accepted into a licensed hospice program.

"Hospice patient's family" shall mean the hospice patient's immediate kin, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the hospice patient may be designated as members of the hospice patient's family by mutual agreement among the hospice patient, the relation or individual, and the hospice team.

"Identifiable hospice administration" means an administrative group, individual or legal entity that has a distinct organizational structure, accountable to the governing authority directly or through a chief executive officer. This administration shall be responsible for the management of all aspects of the program.

"Inpatient" means the provision of services, such as food, laundry, housekeeping, and staff to provide health or health-related services, including respite and symptom management, to hospice patients, whether in a hospital, nursing facility, or hospice facility.

"Interdisciplinary team" means the patient and the patient's family, the attending physician, and the following hospice personnel: physician, nurse, social worker, and trained volunteer. Physician assistants and providers of special services, such as clergy, mental health, pharmacy, and any other appropriate allied health services, may also be included on the team as the needs of the patient dictate.

"Palliative care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient and family as they experience the stress of the dying process, rather than the treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

1981, c. 346; 2007, c. 397; 2022, c. 151.

§ 32.1-162.2. Exemptions from article.

The provisions of this article shall not be applicable to:

1. A hospice established or operated for the practice of religious tenets of any recognized church or denomination which provides care and treatment for the sick by spiritual means without the use of any drug or material remedy, whether gratuitously or for compensation. Such a hospice shall comply with the statutes and regulations governing environmental protection and life safety.

2. Any hospice located in the Commonwealth that after initial licensure is accredited by any organization recognized by the Centers for Medicare and Medicaid Services for the purposes of Medicare certification.

1981, c. 346; 2010, c. 790.

§ 32.1-162.3. License required for hospice programs; notice of denial of license; renewal thereof.

A. No person shall establish or operate a hospice or a hospice facility without a license issued pursuant to this article unless he is exempt from licensure pursuant to § 32.1-162.2.

B. The Commissioner shall issue or renew a license to establish or operate a hospice or a hospice facility upon application therefor on a form and accompanied by a fee prescribed by the Board if the Commissioner finds that the hospice or hospice facility is in compliance with the provisions of this

article and regulations of the Board. The Commissioner shall notify by certified mail any applicant denied a license of the reasons for such denial.

C. Every such license shall expire at midnight December 31 of the year issued, or as otherwise specified by the Board, and shall be required to be renewed annually.

D. The activities and services of each applicant for issuance or renewal of a hospice license shall be subject to an inspection and examination by the Commissioner to determine if the hospice is in compliance with the provisions of this article and regulations of the Board.

E. No license issued pursuant to this article may be transferred or assigned.

1981, c. 346; 2003, c. 526; 2007, c. 397; 2010, c. 790.

§ 32.1-162.4. Inspections.

The Commissioner may cause each hospice licensed under this article to be periodically inspected at reasonable times. However, no hospice shall receive additional inspections until all other hospices in the Commonwealth have also been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations, (ii) required by a uniformly applied risk-based schedule established by the Department, (iii) necessary to investigate a complaint regarding the hospice, or (iv) otherwise deemed necessary by the Commissioner or his designee to protect the health and safety of the public.

Notwithstanding the foregoing or any other provision of this article, any hospice organization that has obtained accreditation as provided in subdivision 2 of § 32.1-162.2, may be subject to inspection so long as such accreditation is maintained but only to the extent necessary to ensure the public health and safety. If any such hospice fails to comply with the provisions of this article or with the regulations of the Board relating to public health and safety, the Commissioner may revoke the exemption from licensure and require such hospice to be relicensed before it can again qualify for an exemption pursuant to § 32.1-162.2.

1981, c. 346; 2010, c. 790; 2017, c. 465.

§ 32.1-162.5. Regulations.

A. The Board shall prescribe such regulations governing the activities and services provided by hospices as may be necessary to protect the public health, safety and welfare. Such regulations shall include, but not be limited to, the requirements for: the qualifications and supervision of licensed and nonlicensed personnel; the standards for the care, treatment, health, safety, welfare, and comfort of patients and their families served by the program; the management, operation, staffing and equipping of the hospice program or hospice facility; clinical and business records kept by the hospice or hospice facility; and procedures for the review of utilization and quality of care. To avoid duplication in regulations, the Board shall incorporate regulations applicable to facilities licensed as hospitals or nursing homes under Article 1 (§ 32.1-123 et seq.) and to organizations licensed as home care organizations under Article 7.1 (§ 32.1-162.7 et seq.) that are also applicable to hospice programs in the regulations to govern hospices. A person who seeks a license to establish or operate a hospice and who

has a preexisting valid license to operate a hospital, nursing home, or home care organization shall be considered in compliance with those regulations that are applicable to both a hospice and the facility for which it has a license.

B. Notwithstanding any law or regulation to the contrary, regulations for hospice facilities shall include minimum standards for design and construction consistent with the Hospice Care section of the current edition of the Guidelines for Design and Construction of Hospital and Health Care Facilities issued by the American Institute of Architects Academy of Architecture for Health.

C. Regulations for hospices shall require each hospice facility to establish a protocol to allow each patient to receive visits, consistent with guidance from the Centers for Disease Control and Prevention and as directed by the Centers for Medicare and Medicaid Services and the Board, during a public health emergency related to COVID-19. Such protocol shall include provisions describing (i) the conditions, including conditions related to the presence of COVID-19 in the hospice facility and community, under which in-person visits will be allowed and under which in-person visits will not be allowed and visits will be required to be virtual; (ii) the requirements with which in-person visitors will be required to comply to protect the health and safety of patients and staff of the hospice facility; (iii) the types of technology, including interactive audio or video technology, and the staff support necessary to ensure visits are provided as required by this subsection; and (iv) the steps the hospice facility will take in the event of a technology failure, service interruption, or documented emergency that prevents visits from occurring as required by this subsection. Such protocol shall also include (a) a statement of the frequency with which visits, including virtual and in-person, where appropriate, will be allowed, which shall be at least once every 10 calendar days for each patient; (b) a provision authorizing a patient or the patient's personal representative to waive or limit visitation, provided that such waiver or limitation is included in the patient's health record; and (c) a requirement that each hospice facility publish on its website or communicate to patients or their personal representatives, in writing or via electronic means, the hospice facility's plan for providing visits to patients as required by this subsection.

D. During a declared public health emergency related to a communicable disease of public health threat, regulations governing hospices shall require each hospice facility to establish a protocol to allow patients to receive visits from a rabbi, priest, minister, or clergy of any religious denomination or sect consistent with guidance from the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services and subject to compliance with any executive order, order of public health, Department guidance, or any other applicable federal or state guidance having the effect of limiting visitation. Such protocol may restrict the frequency and duration of visits and may require visits to be conducted virtually using interactive audio or video technology. Any such protocol may require the person visiting a patient pursuant to this subsection to comply with all reasonable requirements of the hospice adopted to protect the health and safety of the person, patients, and staff of the hospice.

1981, c. 346; 2007, c. 397; 2020, Sp. Sess. I, cc. 10, 11; 2021, Sp. Sess. I, c. 525.

§ 32.1-162.5:1. Notice to dispenser of patient's death; disposition of dispensed drugs.

A. Any hospice licensed by the Department or exempt from licensure pursuant to § 32.1-162.2 with a hospice patient residing at home at the time of death shall notify every pharmacy that has dispensed partial quantities of a Schedule II controlled substance for a patient with a medical diagnosis documenting a terminal illness, as authorized by federal law, within 48 hours of the patient's death.

B. Any hospice licensed by the Department or exempt from licensure pursuant to § 32.1-162.2 shall develop policies and procedures for the disposal of drugs, including opioids, dispensed as part of the hospice plan of care in accordance with the provisions of § 54.1-3411.2.

2015, c. 668; 2018, c. 95; 2020, c. 739.

§ 32.1-162.6. Revocation or suspension of license.

A. The Commissioner is authorized to revoke or suspend any license issued hereunder if the holder of the license fails to comply with the provisions of this article or with the regulations of the Board.

B. If a license is revoked as herein provided, the Commissioner may issue a new license upon application therefor if, when, and after the conditions upon which revocation was based have been corrected and all provisions of this article and applicable regulations have been complied with.

C. Suspension of a license shall in all cases be for an indefinite time and the suspension may be lifted and rights under the license fully or partially restored at such time as the Commissioner determines that the rights of the licensee appear to so require and the interests of the public will not be jeopardized by resumption of operation.

1981, c. 346.

§ 32.1-162.6:1. (Effective until January 1, 2024) Possession or administration of cannabis oil.

Hospice and hospice facility employees who are authorized to possess, distribute, or administer medications to patients shall be permitted to store, dispense, or administer cannabis oil to a patient who has been issued a valid written certification for the use of cannabis oil in accordance with subsection B of § 54.1-3408.3 and has registered with the Board of Pharmacy.

2020, c. 846.

§ 32.1-162.6:1. (Effective January 1, 2024) Possession or administration of cannabis oil.

Hospice and hospice facility employees who are authorized to possess, distribute, or administer medications to patients shall be permitted to store, dispense, or administer cannabis oil to a patient who has been issued a valid written certification for the use of cannabis oil in accordance with § 4.1-1601.

2020, c. 846; 2023, cc. 740, 773.

Article 7.1 - HOME CARE ORGANIZATION LICENSING

§ 32.1-162.7. Definitions.

As used in this article:

"Health care professional" means any professional who is licensed, certified or registered to practice by a board within the Department of Health Professions under Title 54.1 or is licensed, certified or registered by a nationally recognized professional organization specified in Board regulations.

"Home care organization" means a public or private organization, whether operated for profit or not for profit, that provides, at the residence of a patient or individual in the Commonwealth of Virginia, one or more of the following services:

1. Home health services, including services provided by or under the direct supervision of any health care professional under a medical plan of care in a patient's residence on a visit or hourly basis to patients who have or are at risk of injury, illness, or a disabling condition and require short-term or long-term interventions;

2. Personal care services, including assistance in personal care to include activities of daily living provided in an individual's residence on a visit or hourly basis to individuals who have or are at risk of an illness, injury or disabling condition; or

3. Pharmaceutical services, including services provided in a patient's residence, which include the dispensing and administration of a drug or drugs, and parenteral nutritional support, associated patient instruction, and such other services as identified by the Board of Health by regulation.

"Person" includes any partnership, corporation, association or other legal entity, public or private.

"Residence" means the place where the individual or patient makes his home such as his own apartment or house, a relative's home or an assisted living facility, but shall not include a hospital, nursing facility or nursing home or other extended care facility.

1986, c. 633; 1991, c. 695; 1993, cc. 957, 993.

§ 32.1-162.8. Exemptions from article.

The provisions of this article shall not be applicable to:

1. A natural person who provides services to a patient or individual on an individual basis if such person is (i) acting alone under a medical plan of care and is licensed to provide such services pursuant to Title 54.1 or (ii) retained by the individual or by another individual acting on the individual's behalf.

2. Any organization providing only housekeeping, chore or beautician services.

3. Any home care organization located in the Commonwealth that after initial licensure is:

a. Certified by the Department of Health under provisions of Title XVIII or Title XIX of the Social Security Act;

b. Accredited by any organization recognized by the Centers for Medicare and Medicaid Services for the purposes of Medicare certification; or

c. Licensed for hospice services under Article 7 (§ 32.1-162.1 et seq.) of this chapter.

1986, c. 633; 1991, c. 695; 1995, c. 455; 2001, c. 515; 2010, c. 790.

§ 32.1-162.9. Licenses required; renewal thereof.

A. No person shall establish or operate a home care organization without a license issued pursuant to this article unless he is exempt from licensure pursuant to § 32.1-162.8. No license to establish or operate a home care organization shall be issued to any person who has been sanctioned pursuant to 42 U.S.C. § 1320a-7b.

B. The Commissioner shall issue or renew a license to establish or operate a home care organization upon application therefor on a form and accompanied by a fee prescribed by the Board if the Commissioner finds that the home care organization is in compliance with the provisions of this article and regulations of the Board, unless the Commissioner determines that no reciprocal agreement for the licensing of home care organizations has been entered into by the Commonwealth with the state in which the applicant resides or with the state in which the applicant's home care organization is licensed to operate. The Commissioner shall not issue or renew a license to establish or operate a home care organization to any applicant who has been sanctioned pursuant to 42 U.S.C. § 1320a-7b.

C. Any licensed home care organization may establish one or more branch offices serving portions of the total geographic area served by the licensee, provided that each branch office operates under the supervision and administrative control of the licensee. The address of each branch office at which services are provided by the licensee shall be submitted to the Department and included on any license issued to the licensee. Branch offices shall be operated under the initial license issued to the home care organization and shall not be required to obtain an additional license. Upon receipt of notice that a home care organization has established a branch office that meets the criteria set forth in this subsection, the Department shall issue an updated license including the address of the newly established branch office to the home care organization within 10 business days.

D. Every applicant for an initial license to establish or operate a home care organization shall include as part of his application proof of initial reserve operating funds in an amount determined by the Board, which shall be sufficient to ensure operation of the home care organization for the three-month period after a license to operate has been issued. Such funds may include cash, cash equivalents that are readily convertible to known amounts of cash and that present insignificant risk of change in value, borrowed funds that are immediately available to the applicant, or a line of credit that is immediately available to the applicant. Proof of funds sufficient to meet the requirements of this subsection shall include a current balance sheet demonstrating availability of cash or cash equivalents, including all borrowed funds, sufficient to meet the requirement for initial reserve operating funds together with a letter from the officer of the bank or other financial institution where the funds are held or a letter of credit from a lender demonstrating the current availability of a line of credit and the amount thereof.

E. Every such license shall expire on the third anniversary of its issuance or renewal.

F. The activities and services of each applicant for issuance or renewal of a home care organization license shall be subject to an inspection or examination by the Commissioner to determine if the home care organization is in compliance with the provisions of this article and regulations of the Board.

G. No license issued pursuant to this article may be transferred or assigned.

H. Upon renewal of a license, the Department shall not require a home care organization to submit financial documents other than those required for initial licensure.

1986, c. 633; 1991, c. 695; 1994, c. 902; 2012, c. 139; 2013, cc. 184, 505; 2018, c. 105; 2022, c. 172.

§ 32.1-162.9:1. Employment for compensation of persons convicted of barrier crimes prohibited; criminal records check required; drug testing; suspension or revocation of license.

A. A licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1 shall not hire for compensated employment, persons who have been convicted of any offense set forth in clause (i) of the definition of barrier crime in § 19.2-392.02.

However, a home care organization or hospice may hire an applicant who has been convicted of one such offense punishable as a misdemeanor that does not involve abuse or neglect if five years have elapsed since the conviction.

Any person desiring to work at a licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 or any licensed hospice as defined in § 32.1-162.1 shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges, whether within or outside the Commonwealth. Any person making a materially false statement when providing such sworn statement or affirmation regarding any such offense is guilty upon conviction of a Class 1 misdemeanor. Further dissemination of the information provided pursuant to this section is prohibited other than to a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

Such home care organization or hospice shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange. However, no employee shall be permitted to work in a position that involves direct contact with a patient until an original criminal record clearance or original criminal history record has been received, unless such person works under the direct supervision of another employee for whom a background check has been completed in accordance with the requirements of this section. The provisions of this section shall be enforced by the Commissioner. If an applicant is denied employment because of convictions appearing on his criminal history record, the home care organization or hospice shall provide a copy of the information obtained from the Central Criminal Records Exchange to the applicant.

The provisions of this section shall not apply to volunteers who work with the permission or under the supervision of a person who has received a clearance pursuant to this section.

B. Notwithstanding any other provision of law, a licensed home care agency, a home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8, or any licensed hospice as defined in § 32.1-162.1 that provides services to individuals receiving services under the state plan for

medical assistance services or any waiver thereto may disclose to the Department of Medical Assistance Services (i) whether a criminal history background check has been performed on an employee of the home care agency in accordance with this section and (ii) whether such person is eligible for employment.

C. A licensed home care organization as defined in § 32.1-162.7 or any home care organization exempt from licensure under subdivision 3 a or b of § 32.1-162.8 shall establish policies for maintaining a drug-free workplace, which may include drug testing when the employer has cause to believe that the person has engaged in the use of illegal drugs and periodically during the course of employment. All positive results from drug testing administered pursuant to this section shall be reported to the health regulatory boards responsible for licensing, certifying, or registering the person to practice, if any.

D. A person who complies in good faith with the provisions of this section shall not be liable for any civil damages for any act or omission in the performance of duties under this section unless the act or omission was the result of gross negligence or willful misconduct.

E. A licensed home care organization or hospice shall notify and provide all students a copy of the provisions of this section prior to or upon enrollment in a certified nurse aide program operated by such home care organization or hospice.

1992, c. 844; 1993, cc. 17, 657; 1999, c. 637; 2003, c. 517; 2006, cc. 701, 764; 2010, cc. 415, 790; 2012, c. 383; 2014, c. 129; 2017, c. 809; 2019, c. 89.

§ 32.1-162.10. Inspections; fees.

State agencies shall make or cause to be made only such inspections of home care organizations as are necessary to carry out the various obligations imposed on each agency by applicable state and federal laws and regulations. However, no home care organization shall receive additional inspections until all other home care organizations in the Commonwealth have also been inspected, unless the additional inspections are (i) necessary to follow up on a preoperational inspection or one or more violations, (ii) required by a uniformly applied risk-based schedule established by the Department, (iii) necessary to investigate a complaint regarding the home care organization, or (iv) otherwise deemed necessary by the Commissioner or his designee to protect the health and safety of the public.

Any on-site inspection by a state agency or a division or unit thereof that substantially complies with the inspection requirements of any other state agency or any other division or unit of the inspecting agency charged with making similar inspections shall be accepted as an equivalent inspection in lieu of an on-site inspection by said agency or by a division or unit of the inspecting agency. A state agency shall coordinate its inspections of home care organizations both internally and with those required by other state agencies so as to ensure that the requirements of this section are met.

Notwithstanding any provision of law to the contrary, all home care organizations licensed by the Department of Health that have been certified under the provisions of Title XVIII of the Social Security Act for home care services or have obtained accreditation by any organization recognized by the

Centers for Medicare and Medicaid Services for the purposes of Medicare certification may be subject to inspection so long as such accreditation or certification is maintained but only to the extent necessary to ensure the public health and safety. If any such home care organization fails to comply with the provisions of this article or with the regulations of the Board relating to public health and safety, the Commissioner is authorized to revoke the exemption from licensure and require such organization to be relicensed before it can again qualify for an exemption pursuant to § 32.1-162.8.

1986, c. 633; 1991, c. 695; 2010, c. 790; 2014, c. 324; 2017, c. 465.

§ 32.1-162.11. Liability insurance required.

Every licensed home care organization shall obtain and maintain a liability insurance policy and third-party crime insurance policy or blanket fidelity bond in accordance with regulations of the Board. Such insurance policy or bond shall provide coverage in an amount sufficient to compensate patients or individuals for injuries and losses resulting from the negligent or criminal acts of the licensee. Failure to maintain these requirements shall result in revocation of the home care organization's license.

1986, c. 633; 1991, c. 695; 2013, c. 184.

§ 32.1-162.12. Regulations.

The Board shall prescribe such regulations governing the activities and services provided by home care organizations as may be necessary to protect the public health, safety, and welfare. Such regulations shall include, but not be limited to, an informed consent contract, the qualifications and supervision of licensed and nonlicensed personnel, a complaint procedure for consumers, the provision and coordination of treatment and services provided by the organization, clinical records kept by the organization, utilization and quality control review procedures, and arrangements for the continuing evaluation of the quality of care provided. Regulations shall be appropriate for the categories of service defined in § 32.1-162.7. Regulations governing the delivery of personal care services shall provide for supervision of home care attendants providing personal care services by a licensed nurse through use of interactive audio or video technology.

1986, c. 633; 1991, c. 695; 2021, Sp. Sess. I, c. 470.

§ 32.1-162.13. Revocation or suspension of license.

A. The Commissioner is authorized to revoke or suspend any license issued hereunder if the holder of the license fails to comply with the provisions of this article or with the regulations of the Board.

B. If a license is revoked as herein provided, the Commissioner may issue a new license upon application therefor if, when, and after the conditions upon which revocation was based have been corrected and all provisions of this article and applicable regulations have been complied with.

C. Whenever a license is revoked or suspended the Commissioner may request the Office of the Attorney General to petition the circuit court of the jurisdiction in which the home care organization is located for an injunction to cause such home care organization to cease providing services.

D. Suspension of a license shall in all cases be for an indefinite time and the suspension may be lifted and rights under the license fully or partially restored at such time as the Commissioner determines that the rights of the licensee appear to so require and the interests of the public will not be jeopardized by resumption of operation.

E. The Commissioner shall notify the Department of Medical Assistance Services whenever any license is revoked, suspended, or expired for the purpose of terminating or suspending the licensee Medicaid provider agreement.

1986, c. 633; 1991, c. 695; 2010, c. 790.

§ 32.1-162.14. Repealed.

Repealed by Acts 2003, c. 449.

§ 32.1-162.15. Violation; penalties.

Any person owning, establishing, conducting, maintaining, managing or operating a home care organization which is not licensed as required by this article shall be guilty of a Class 6 felony. The Commissioner may request the Office of the Attorney General to petition the circuit court of the jurisdiction in which the nonlicensed home care organization is located for an injunction to cause such nonlicensed home care organization to cease providing services.

1991, c. 695; 2010, c. 790.

§ 32.1-162.15:1. Unlawful advertising as a home care organization.

It shall be unlawful for any person not licensed as a home care organization pursuant to this article or exempt from licensure pursuant to subsection 3 of § 32.1-162.8, or whose license as a home care organization has been suspended or revoked, or whose license as a home care organization has lapsed and has not been renewed to knowingly advertise or market himself as or otherwise hold himself out to be a home care organization under § 32.1-162.7 or to otherwise assert or imply that he is licensed to provide home health, personal care, or pharmaceutical services. For the purposes of this section, a person who solely offers referrals of independent providers of home care or personal care services, and who advertises or markets himself as such, shall not be deemed to be holding himself out as, or asserting or implying that he is, a home care organization or otherwise licensed to provide home health or personal care services.

2015, c. 304.

Article 8 - Services for Survivors of Sexual Assault

§ 32.1-162.15:2. Definitions.

"Anonymous physical evidence recovery kit" has the same meaning as in § 19.2-11.5.

"Approved pediatric health care facility" means a pediatric health care facility for which a plan for the delivery of services to pediatric survivors of sexual assault has been approved pursuant to § 32.1-162.15:6.

"Board" means the Board of Health.

"Department" means the Department of Health.

"Emergency contraception" means medication approved by the U.S. Food and Drug Administration that can significantly reduce the risk of pregnancy if taken within 72 hours after sexual assault.

"Follow-up health care" means any physical examination, laboratory tests to determine the presence of sexually transmitted infection, or appropriate medications, including HIV-prophylaxis, provided to a survivor of sexual assault by a health care provider within 90 days after the date on which treatment or transfer services pursuant to this article are first provided.

"Forensic medical examination" means health care services provided to a survivor of sexual assault that include medical history, physical examination, laboratory testing, assessment for drug-facilitated or alcohol-facilitated sexual assault, collection of evidence in accordance with the requirements of Chapter 1.2 (§ 19.2-11.5 et seq.) of Title 19.2, and discharge and follow-up health care planning necessary to ensure the health, safety, and welfare of the survivor of sexual assault and the collection and preservation of evidence that may be used in a criminal proceeding.

"Hospital" means any hospital licensed by the Department pursuant to this chapter.

"Pediatric health care facility" means a hospital, clinic, or physician's office that provides health care services to pediatric patients.

"Pediatric survivor of sexual assault" means a survivor of sexual assault who is under 18 years of age.

"Physical evidence recovery kit" has the same meaning as in § 19.2-11.5.

"Sexual assault forensic examiner" means a sexual assault nurse examiner, a physician, a physician assistant, an advanced practice registered nurse, or a registered nurse who has completed training that meets or is substantially similar to the Sexual Assault Nurse Examiner Education Guidelines established by the International Association of Forensic Nurses.

"Sexual assault survivor transfer services" means an appropriate medical examination and such stabilizing treatment as may be necessary prior to the transfer of a sexual assault survivor from a transfer hospital to a treatment hospital in accordance with the provisions of a transfer plan approved by the Department.

"Sexual assault survivor treatment services" means a forensic medical examination and other health care services provided to a sexual assault survivor by a hospital in accordance with § 32.1-162.15:4 or pediatric health care facility in accordance with § 32.1-162.15:6.

"Transfer hospital" means a hospital with a sexual assault survivor transfer plan approved by the Department.

"Transportation service" means transportation provided to a survivor of sexual assault who is transferred from a transfer hospital, treatment hospital, or approved pediatric health care facility to a treatment hospital or approved pediatric care facility pursuant to a transfer plan approved in accordance with this article.

"Treatment hospital" means a hospital with a sexual assault survivor treatment plan approved by the Department to provide sexual assault survivor treatment services to all survivors of sexual assault who present with a complaint of sexual assault within the previous seven days or who have disclosed past sexual assault by a specific individual and were in the care of that individual within the previous seven days.

2020, c. 725; 2022, c. 520; 2023, c. 183.

§ 32.1-162.15:3. (Effective July 1, 2023) Services for survivors of sexual assault; plan required.

A. Every hospital licensed by the Department shall develop and, upon approval by the Department, implement a plan to provide either sexual assault survivor treatment services or sexual assault survivor transfer services for survivors of sexual assault.

B. Sexual assault survivor treatment plans shall include provisions for (i) the delivery of services described in § 32.1-162.15:4 and (ii) the storage, retention, and dissemination of photographic evidence in accordance with § 32.1-162.15:8.

C. Sexual assault survivor transfer service plans shall include (i) provisions for the delivery of services described in § 32.1-162.15:5 and (ii) the written agreement of a treatment hospital to accept transfer of survivors of sexual assault.

D. A treatment hospital for which a plan has been approved pursuant to subsection B or a transfer hospital for which a plan has been approved pursuant to subsection C may enter into an agreement for the transfer of pediatric survivors of sexual assault from the treatment hospital or transfer hospital to an approved pediatric health care facility pursuant to a pediatric sexual assault survivor transfer plan. Such plan shall include (i) provisions for the delivery of services described in § 32.1-162.15:6 and (ii) the written agreement of an approved pediatric health care facility to accept transfer of survivors of sexual assault.

E. Sexual assault survivor treatment plans, sexual assault survivor transfer plans, and pediatric sexual assault survivor transfer plans shall be submitted in a form and in accordance with procedures specified by the Board. The Department shall approve or deny such plans, in writing, within 30 days of receipt of such plans. If the Department denies a plan submitted pursuant to this section, the Department shall provide the hospital with a written statement setting forth the reasons for such denial.

2020, c. 725.

§ 32.1-162.15:4. (For effective date, see Acts 2020, c 725) Treatment services.

A. The Board shall adopt regulations to establish standards for review and approval of sexual assault survivor treatment plans, which shall include provisions for the following services, when ordered by a health care provider and with the consent of the survivor of sexual assault:

1. Appropriate forensic medical examination;

2. Appropriate oral and written information concerning the possibility of infection or sexually transmitted disease, including human immunodeficiency virus (HIV) resulting from the sexual assault,

accepted medical procedures and medications for the prevention or treatment of such infection or sexually transmitted disease, and the indications, contraindications, and potential risks of such medical procedures or medications;

3. Appropriate evaluations to determine the survivor of sexual assault's risk of infection or sexually transmitted disease, including HIV, resulting from the sexual assault;

4. Appropriate oral and written information regarding the possibility of pregnancy resulting from the sexual assault and medically and factually accurate oral and written information about emergency contraception, the indications and contraindications and potential risks associated with the use of emergency contraception, and the availability of emergency contraception for survivors of sexual assault;

5. Prescriptions of such medications as may be appropriate for treatment of the survivor of sexual assault both during treatment at the hospital and upon discharge, including, in cases in which prophylactic treatment for infection with HIV is deemed appropriate, an initial dose or all required doses of HIV prophylaxis;

6. Oral and written information regarding the need for follow-up care, including examinations and laboratory tests to determine the presence or absence of sexually transmitted infection or disease and follow-up care related to HIV prophylaxis;

7. Information about medical advocacy services provided by a rape crisis center with which the hospital has entered into a memorandum of understanding pursuant to subsection D; and

8. Referral for appropriate counseling and other support services.

B. All appropriate sexual assault survivor treatment services shall be provided without delay in a private location and in an age-appropriate or developmentally appropriate manner.

C. Forensic medical examinations provided pursuant to a sexual assault survivor treatment plan approved by the Board shall include an offer to complete a physical evidence recovery kit. Every treatment hospital for which a sexual assault survivor treatment plan has been approved by the Department shall report to the Department by December 1 of each year:

1. The total number of patients to whom a forensic medical examination was provided; and

2. The total number of physical evidence recovery kits offered and completed.

D. Every treatment hospital shall (i) enter into a memorandum of understanding with at least one rape crisis center for medical advocacy services for survivors of sexual assault and (ii) adopt procedures to ensure compliance with mandatory reporting requirements pursuant to §§ 63.2-1509 and 63.2-1606.

E. Records of services provided to survivors of sexual assault, including the results of any examination or laboratory test conducted pursuant to subsection A, shall be maintained by the treatment hospital and made available to law enforcement upon request of the survivor of sexual assault. Records of services provided to survivors of sexual assault 18 years of age and older shall be maintained by the hospital for a period of 20 years from the date the record was created. Records of

services provided to survivors of sexual assault under 18 years of age shall be maintained for a period of 20 years after the date on which the survivor of sexual assault reaches 18 years of age.

F. Every treatment hospital, including every treatment hospital with an approved pediatric sexual assault survivor plan, shall include in its sexual assault survivor treatment plan provisions requiring appropriate health care providers who provide services in the hospital's emergency department to annually complete training developed and made available by the Department on the topic of sexual assault, detection of sexual assault, provision of services for survivors of sexual assault, and collection of evidence in cases involving alleged sexual assault. Such training shall be consistent with best practices outlined by the International Association of Forensic Nurses.

2020, c. 725.

§ 32.1-162.15:5. Transfer services.

The Board shall adopt regulations to establish standards for review and approval of sexual assault survivor transfer plans and pediatric sexual assault survivor transfer plans, which shall include provisions for the following services, when ordered by a health care provider and with the consent of the survivor of sexual assault:

1. Appropriate medical examination and such stabilizing treatment as may be necessary prior to the transfer of a survivor of sexual assault from the transfer hospital to a treatment hospital or clinic that provides treatment services for survivors of sexual assault that are comparable to those described in § 32.1-162.15:4;

2. Medically and factually accurate written and oral information about emergency contraception, the indications and contraindications and potential risks associated with the use of emergency contraception, and the availability of emergency contraception for survivors of sexual assault; and

3. Prompt transfer of the survivor of sexual assault to a treatment hospital, approved pediatric health care facility, or clinic that provides treatment services for survivors of sexual assault that are comparable to those described in § 32.1-162.15:4, as may be appropriate, including provisions necessary to ensure that transfer of the survivor of sexual assault or pediatric survivor of sexual assault would not unduly burden the survivor of sexual assault or pediatric survivor of sexual assault.

2020, c. 725; 2022, c. 520.

§ 32.1-162.15:6. (Effective July 1, 2023) Services for pediatric survivors of sexual assault; plan required.

A. A pediatric health care facility may provide treatment services or transfer services to pediatric survivors of sexual assault in accordance with a pediatric sexual assault survivor treatment plan or pediatric sexual assault survivor transfer plan approved by the Department. No pediatric health care facility shall provide pediatric sexual assault treatment or transfer services to a pediatric survivor of sexual assault unless a pediatric sexual assault survivor treatment plan for the pediatric health care facility has been approved by the Department.

B. A pediatric health care facility wishing to provide pediatric sexual assault survivor treatment services shall submit a pediatric sexual assault survivor treatment plan to the Department. The Board shall adopt regulations to establish standards for the review and approval of pediatric sexual assault survivor treatment plans, which shall include provisions for the delivery of treatment services described in § 32.1-162.15:4.

In cases in which the pediatric health care facility is not able to provide the full range of treatment services required by § 32.1-162.15:4, the plan shall include (i) the specific treatment services that the pediatric health care facility will provide for pediatric survivors of sexual assault; (ii) provisions for transfer services required by § 32.1-162.15:5 for pediatric survivors of sexual assault for whom treatment services are not provided by the pediatric health care facility; (iii) the written agreement of a treatment hospital to accept transfer of pediatric survivors of sexual assault for whom treatment services are not provided by the pediatric health care facility; and (iv) if the pediatric health care facility does not provide services 24 hours per day, seven days per week, provisions to inform the public regarding the need to seek an alternative source of treatment, including emergency medical services, which may include requirements for appropriate signage.

C. A pediatric health care facility wishing to provide pediatric sexual assault survivor transfer services shall submit a pediatric sexual assault survivor transfer plan to the Department. The Board shall adopt regulations to establish standards for review and approval of pediatric sexual assault survivor transfer plans, which shall include provisions for (i) the delivery of sexual assault survivor transfer services in accordance with the requirements of § 32.1-162.15:5 and (ii) the written agreement of a treatment hospital to accept transfer of pediatric survivors of sexual assault.

D. Pediatric sexual assault survivor treatment plans and pediatric sexual assault survivor transfer plans shall be submitted in a form and in accordance with procedures specified by the Board. The Department shall approve or deny such plans, in writing, within 30 days of receipt of such plans. If the Department denies a plan submitted pursuant to this section, the Department shall provide the hospital with a written statement setting forth the reasons for such denial.

2020, c. 725.

§ 32.1-162.15:7. (Effective July 1, 2023) Inspections; report required.

A. The Department shall periodically conduct such inspections of hospitals licensed by the Department as may be necessary to ensure that sexual assault survivor treatment plans, sexual assault survivor transfer plans, and pediatric sexual assault survivor transfer plans are implemented in accordance with the requirements of this article.

B. The Department shall report to the Governor and the General Assembly by December 1 of each year on:

1. The name of each hospital that has submitted a sexual assault survivor treatment plan, sexual assault survivor transfer plan, or pediatric sexual assault survivor transfer plan in accordance with the

requirements of this section and, for each hospital, the specific type of plan, the date on which the plan was submitted, and the date on which the plan was approved;

2. The name of each hospital that has failed to submit a sexual assault survivor treatment plan, sexual assault survivor transfer plan, or pediatric sexual assault survivor transfer plan in accordance with the requirements of this section;

3. The name of each hospital for which an inspection was performed pursuant to subsection A and for each such hospital, the date of such inspection, and whether the hospital was found to be in compliance with the provisions of the sexual assault survivor treatment plan, sexual assault survivor transfer plan, or pediatric sexual assault survivor transfer plan for such hospital approved by the Department; and

4. For each hospital determined to be out of compliance with the requirements of the sexual assault survivor treatment plan, sexual assault survivor transfer plan, or pediatric sexual assault survivor transfer plan for such hospital approved by the Department, whether a plan of correction was submitted in accordance with the provisions of subsection A.

2020, c. 725.

§ 32.1-162.15:8. (Effective July 1, 2023) Storage, retention, and dissemination of photographic documentation.

Photographic documentation collected by a treatment hospital or approved pediatric health care facility shall be maintained by the treatment hospital or approved pediatric health care facility as part of the patient's forensic medical examination. In the case of an anonymous physical evidence recovery kit, photographic documentation shall be maintained by the treatment hospital or approved pediatric health care facility, but the anonymous physical evidence recovery kit shall be maintained in accordance with § 19.2-11.6.

2020, c. 725.

§ 32.1-162.15:9. (Effective July 1, 2023) Submission of evidence.

Every treatment hospital and approved pediatric health care facility that provides a forensic medical examination that includes completion of a physical evidence recovery kit to a survivor of sexual assault who has elected to report the assault to law enforcement shall notify the law-enforcement agency with the primary responsibility for investigating an alleged sexual assault within four hours of the forensic medical examination and arrange for collection of the physical evidence recovery kit within a reasonable timeframe. A treatment hospital or approved pediatric health care facility that provides a forensic medical examination that includes completion of a physical evidence recovery kit to a survivor of sexual assault who elects not to report the sexual assault to law enforcement shall comply with the provisions of § 19.2-11.6 relating to anonymous physical evidence recovery kits.

2020, c. 725.

§ 32.1-162.15:10. (Effective July 1, 2023) Complaints.

The Department shall establish a process for receiving complaints regarding alleged violations of this article.

2020, c. 725.

§ 32.1-162.15:11. Task Force on Services for Survivors of Sexual Assault.

A. There is hereby created the Task Force on Services for Survivors of Sexual Assault (the Task Force), which shall consist of (i) two members of the House of Delegates appointed by the Speaker of the House of Delegates; (ii) one member of the Senate appointed by the Senate Committee on Rules; (iii) the Attorney General, or his designee; (iv) the Commissioners of Health and Social Services, or their designees; (v) the Director of the Department of State Police; (vi) two representatives of hospitals licensed by the Department of Health appointed by the Governor; (vii) three physicians licensed by the Board of Medicine to practice medicine or osteopathy appointed by the Governor, each of whom is a practitioner of emergency medicine and at least one of whom is a pediatrician; (viii) three nurses licensed to practice in the Commonwealth appointed by the Governor, each of whom is a sexual assault nurse examiner; (ix) two representatives of organizations providing advocacy on behalf of survivors of sexual assault appointed by the Governor; (x) one representative of an organization providing advocacy on behalf of children appointed by the Governor; and (xi) one representative of a forensic clinic appointed by the Governor. The Commissioner of Health or his designee shall serve as chairman of the Task Force. Staff support for the Task Force shall be provided by the Department of Health.

B. The Task Force shall:

1. Develop model treatment and transfer plans for use by transfer hospitals, treatment hospitals, and pediatric health care facilities and work with hospitals and pediatric health care facilities to facilitate the development of treatment and transfer plans in accordance with the requirements of this article;

2. Develop model written transfer agreements for use by treatment hospitals, transfer hospitals, and pediatric health care facilities and work with treatment hospitals, transfer hospitals, and pediatric health care facilities to facilitate the development of transfer agreements in accordance with the requirements of this article;

3. Develop model written agreements for use by treatment hospitals and approved pediatric health care facilities required to enter into agreements with rape crisis centers pursuant to subsection D of § 32.1-162.15:4;

4. Work with treatment hospitals and approved pediatric health care facilities to develop plans to employ or contract with sexual assault forensic examiners to ensure the provision of treatment services to survivors of sexual assault by sexual assault forensic examiners, including plans for implementation of on-call systems to ensure availability of sexual assault forensic examiners;

5. Work with treatment hospitals and approved pediatric health care facilities to identify and recommend processes to ensure compliance with the provisions of this article related to creation, storage, and retention of photographic and other documentation and evidence;

6. Develop and distribute educational materials regarding implementation of the provisions of this article to hospitals, health care providers, rape crisis centers, children's advocacy centers, and others;

7. Study and provide recommendations to the Department for the use of telemedicine in meeting the requirements of this article; and

8. Report to the Governor and the General Assembly by December 1 of each year regarding its activities and the status of implementation of the provisions of this article.

2020, c. 725; 2022, c. 520.

Chapter 5.1 - HUMAN RESEARCH

§ 32.1-162.16. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Human research" means any systematic investigation, including research development, testing and evaluation, utilizing human subjects, that is designed to develop or contribute to generalized knowledge. Human research shall not be deemed to include research exempt from federal research regulation pursuant to 45 C.F.R. § 46.101(b).

"Informed consent" means the knowing and voluntary agreement, without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion, of a person who is capable of exercising free power of choice. For the purposes of human research, the basic elements of information necessary to such consent shall include:

1. A reasonable and comprehensible explanation to the person of the proposed procedures or protocols to be followed, their purposes, including descriptions of any attendant discomforts, and risks and benefits reasonably to be expected;

2. A disclosure of any appropriate alternative procedures or therapies that might be advantageous for the person;

3. An instruction that the person may withdraw his consent and discontinue participation in the human research at any time without prejudice to him;

4. An explanation of any costs or compensation which may accrue to the person and, if applicable, the availability of third party reimbursement for the proposed procedures or protocols; and

5. An offer to answer and answers to any inquiries by the person concerning the procedures and protocols.

"Institution" or "agency" means any facility, program, or organization owned or operated by the Commonwealth, by any political subdivision, or by any person, firm, corporation, association, or other legal entity.

"Legally authorized representative" means, in the following specified order of priority, (i) the parent or parents having custody of a prospective subject who is a minor, (ii) the agent appointed under an advance directive, as defined in § 54.1-2982, executed by the prospective subject, provided the advance directive authorizes the agent to make decisions regarding the prospective subject's participation in human research, (iii) the legal guardian of a prospective subject, (iv) the spouse of the prospective subject, except where a suit for divorce has been filed and the divorce decree is not yet final, (v) an adult child of the prospective subject, (vi) a parent of the prospective subject when the subject is an adult, (vii) an adult brother or sister of the prospective subject or (viii) any person or judicial or other body authorized by law or regulation to consent on behalf of a prospective subject to such subject's participation in the particular human research. For the purposes of this chapter, any person authorized by law or regulation to consent on behalf of a prospective subject to such subject's participation in the particular human research shall include an attorney in fact appointed under a durable power of attorney, to the extent the power grants the authority to make such a decision. The attorney in fact shall not be employed by the person, institution, or agency conducting the human research. No official or employee of the institution or agency conducting or authorizing the research shall be qualified to act as a legally authorized representative.

"Minimal risk" means that the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

"Nontherapeutic research" means human research in which there is no reasonable expectation of direct benefit to the physical or mental condition of the human subject.

1979, c. 38, § 37.1-234; 1986, c. 274; 1992, c. 603; 2002, c. 754.

§ 32.1-162.17. Exemptions.

The following categories of human research are exempt from the provisions of this chapter:

1. Activities of the Virginia Department of Health conducted pursuant to § 32.1-39;

2. Research or student learning outcomes assessments conducted in educational settings involving regular or special education instructional strategies, the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods, or the use of educational tests, whether cognitive, diagnostic, aptitude, or achievement, if the data from such tests are recorded in a manner so that subjects cannot be identified, directly or through identifiers linked to the subjects;

3. Research involving survey or interview procedures unless responses are recorded in such a manner that the subjects can be identified, directly or through identifiers linked to the subjects, and either (i) the subject's responses, if they became known outside the research, could reasonably place the

subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability or (ii) the research deals with sensitive aspects of the subject's own behavior, such as sexual behavior, drug or alcohol use, or illegal conduct;

4. Research involving survey or interview procedures, when the respondents are elected or appointed public officials or candidates for public office;

5. Research involving solely the observation of public behavior, including observation by participants, unless observations are recorded in such a manner that the subjects can be identified, directly or through identifiers linked to the subjects, and either (i) the observations recorded about the individual, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability or (ii) the research deals with sensitive aspects of the subject's own behavior, such as sexual behavior, drug or alcohol use, or illegal conduct; and

6. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in a manner so that subjects cannot be identified, directly or through identifiers linked to the subjects.

1992, c. 603.

§ 32.1-162.18. Informed consent.

A. In order to conduct human research in this Commonwealth, informed consent must be obtained if the person who is to be the human subject is as follows: (i) capable of making an informed decision, then it shall be subscribed to in writing by the person and witnessed; (ii) incapable of making an informed decision, as defined in § 54.1-2982, at the time consent is required, then it shall be subscribed to in writing by the person's legally authorized representative and witnessed; or (iii) a minor otherwise capable of rendering informed consent, then it shall be subscribed to in writing by both the minor and his legally authorized representative. The giving of consent by a legally authorized representative shall be subject to the provisions of subsection B of this section. If two or more persons who qualify as legally authorized representatives and have equal decision-making priority under this chapter inform the principal investigator or attending physician that they disagree as to participation of the prospective subject in human research, the subject shall not be enrolled in the human research that is the subject of the consent. No informed consent form shall include any language through which the person who is to be the human subject waives or appears to waive any of his legal rights, including any release of any individual, institution, or agency or any agents thereof from liability for negligence.

Notwithstanding consent by a legally authorized representative, no person shall be forced to participate in any human research if the investigator conducting the human research knows that participation in the research is protested by the prospective subject. In the case of persons suffering from neurodegenerative diseases causing progressive deterioration of cognition for which there is no

known cure, the implementation of experimental courses of therapeutic treatment, including non-pharmacological treatment, to which a legally authorized representative has given informed consent shall not constitute the use of force.

B. A legally authorized representative may not consent to nontherapeutic research unless it is determined by the human research committee that such nontherapeutic research will present no more than a minor increase over minimal risk to the human subject. A legally authorized representative may not consent to participation in human research on behalf of a prospective subject if the legally authorized representative knows, or upon reasonable inquiry ought to know, that any aspect of the human research protocol is contrary to the religious beliefs or basic values of the prospective subject, whether expressed orally or in writing. A legally authorized representative may not consent to participation in human research involving nontherapeutic sterilization, abortion, psychosurgery or admission for research purposes to a facility or hospital as defined in § 37.2-100.

C. Except as provided elsewhere in this chapter, no investigator may involve a human being as a subject in research covered by this chapter unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the legally authorized representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence.

D. The human research review committee may approve a consent procedure which omits or alters some or all of the basic elements of informed consent, or waives the requirement to obtain informed consent, if the committee finds and documents that (i) the research involves no more than minimal risk to the subjects; (ii) the omission, alteration or waiver will not adversely affect the rights and welfare of the subjects; (iii) the research could not practicably be performed without the omission, alteration or waiver; and (iv) after participation, the subjects are to be provided with additional pertinent information, whenever appropriate.

E. The human research review committee may waive the requirement that the investigator obtain written informed consent for some or all subjects, if the committee finds that the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. The committee may require the investigator to provide the subjects with a written statement explaining the research. Further, each subject shall be asked whether he wants documentation linking him to the research and the subject's wishes shall govern.

1979, c. 38, § 37.1-235; 1986, c. 274; 1992, c. 603; 2002, c. 754; 2016, c. 84.

§ 32.1-162.19. Human research review committees.

A. Each institution or agency which conducts or which proposes to conduct or authorize human research shall establish a human research review committee. The committee shall be composed of representatives of varied backgrounds to ensure the competent, complete, and professional review of human research activities conducted or proposed to be conducted or authorized by the institution or

agency. No member of the committee shall be directly involved in the proposed human research or have administrative approval authority over the proposed human research except in connection with his responsibilities as a member of the committee.

B. No human research shall be conducted or authorized by such institution or agency unless the committee has reviewed and approved the proposed human research project giving consideration to (i) the adequacy of the description of the potential benefits and risks involved and the adequacy of the methodology of the research; (ii) if the research is nontherapeutic, whether it presents more than a minimal risk to the human subjects; (iii) whether the rights and welfare of the human subjects involved are adequately protected; (iv) whether the risks to the human subjects are outweighed by the potential benefits to them; (v) whether the risks to subjects are minimized by using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risk and, whenever appropriate, by using procedures already being performed on the subjects for diagnostic or treatment purposes; (vi) when some or all of the subjects are likely to be incapable of making an informed decision regarding consent or are otherwise vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, whether additional safeguards have been included in the study to protect the rights and welfare of these subjects; (vii) whether the informed consent is to be obtained by methods that are adequate and appropriate and whether the written consent form is adequate and appropriate in both content and language for the particular research; (viii) whether the persons proposing to conduct the particular human research are appropriately competent and qualified; and (ix) whether the criteria for selection of subjects are equitable. The committee shall require periodic reports from each existing human research project to ensure that the project is being carried out in conformity with the proposal as approved.

C. The regulations of an institution or agency may authorize the committee to conduct an expedited review of a human research project which involves no more than minimal risk to the subjects if (i) another institution's or agency's human research review committee has reviewed and approved the project or (ii) the review involves only minor changes in previously approved research and the changes occur during the approved project period.

D. Every person engaged in the conduct of human research or proposing to conduct human research shall affiliate himself with an institution or agency having a research review committee, and the human research which he conducts or proposes to conduct shall be subject to review and approval by such committee in the manner set forth in this section.

E. Each human research review committee of a state institution or agency shall ensure that an overview of approved human research projects and the results of such projects are made public on the institution's or agency's website unless otherwise exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

1979, c. 38, § 37.1-236; 1986, c. 274; 1992, c. 603; 2002, c. 754; 2007, c. 413.

§ 32.1-162.20. Applicability of federal policies.

Human research which is subject to policies and regulations for the protection of human subjects promulgated by any agency of the federal government shall be exempt from the provisions of this chapter.

In lieu of promulgating regulations pursuant to the requirements of this chapter, an institution or agency may comply with this chapter by promulgating regulations under the provisions of the Administrative Process Act (§ 2.2-4000 et seq.) governing human research projects which incorporate, explicitly or by reference, federal policies and regulations for the protection of human subjects. However, in the case of projects which are not required, by reason of their nature, the source of their funding, or the lack thereof, to comply with federal policies and regulations, the institution or agency may enforce compliance by filing a petition for an injunction in the appropriate circuit court. This section shall not preclude any other enforcement action available to the institution or agency.

1979, c. 38, § 37.1-237; 1992, c. 603.

Chapter 5.2 - HUMAN CLONING

§ 32.1-162.21. Definitions.

As used in this chapter, unless the context clearly requires another meaning:

"Cloning" means the production of a precise genetic copy of a molecule, including deoxyribonucleic acid (DNA), or of chromosomes.

"Human cloning" means the creation of or attempt to create a human being by transferring the nucleus from a human cell from whatever source into an oocyte from which the nucleus has been removed.

"Nucleus" means the cell structure that houses the chromosomes and, thus, the genes.

"Oocyte" means the ovum or egg.

"Somatic cell" means a mature, diploid cell, i.e., a cell having a complete set of chromosomes.

"Somatic cell nuclear transfer" means transferring the nucleus of a somatic cell of an existing or deceased human into an oocyte from which the chromosomes are removed or rendered inert.

2001, cc. 868, 870.

§ 32.1-162.22. Human cloning prohibited; civil penalty.

A. No person shall (i) perform human cloning or (ii) implant or attempt to implant the product of somatic cell nuclear transfer into a uterine environment so as to initiate a pregnancy or (iii) possess the product of human cloning or (iv) ship or receive the product of a somatic cell nuclear transfer in commerce for the purpose of implanting the product of somatic cell nuclear transfer into a uterine environment so as to initiate a pregnancy.

B. This section shall not be construed to restrict biomedical and agricultural research or practices unless expressly prohibited herein, including research or practices that involve the use of (i) somatic cell nuclear transfer or other cloning technologies to clone molecules, including DNA, cells, or tissues; (ii) gene therapy; or (iii) somatic cell nuclear transfer techniques to create animals other than humans.

C. In addition to any other penalty provided by law, any person violating the provisions of this section shall be liable for a civil penalty in an amount not to exceed $50,000 for each incident.

2001, cc. 868, 870.

Chapter 5.3 - COMMONWEALTH HEALTH RESEARCH BOARD AND FUND; CHRISTOPHER REEVE STEM CELL RESEARCH FUND

§ 32.1-162.23. Commonwealth Health Research Board established.

A. The Commonwealth Health Research Board (the Board) is established as an independent body. The purpose of the Board is to provide financial support from the Commonwealth Health Research Fund (the Fund), in the form of grants, donations, or other assistance, for research efforts that have the potential of maximizing human health benefits for the citizens of the Commonwealth. Research efforts eligible for support by the Board shall include traditional medical and biomedical research relating to health services, the delivery of health care, and the causes and cures of diseases.

B. The Board shall be composed of seven members, of whom three shall be appointed by the Governor and four shall be appointed by the Joint Rules Committee. All appointments to the Board are subject to confirmation by the General Assembly. Appointments shall be for terms of five years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments.

No member shall serve more than two consecutive five-year terms; however, a member appointed to serve an unexpired term is eligible to serve two additional consecutive five-year terms immediately succeeding such unexpired term.

C. Members of the Board shall have substantial experience or expertise, personal or professional, in at least one of the following areas: medicine, medical or scientific research, public policy, government, business, or education. No member shall be an incumbent elected official, state official, state employee, or member of the governing board of a state agency or institution. Members of the Board need not be residents of the Commonwealth.

D. The Board shall elect annually a chairman and vice-chairman from among its membership. The chairman, or in his absence the vice-chairman, shall preside at all meetings of the Board.

E. A majority of the members of the Board serving at any one time shall constitute a quorum for the transaction of business.

F. The Board shall meet annually or more frequently at the call of the chairman.

G. The members of the Board shall receive no compensation for their services but shall be reimbursed for the reasonable and necessary expenses incurred in the performance of their duties as provided in § 2.2-2825. Such expenses shall be paid from the Fund.

1997, cc. 803, 888, 891, § 23-278; 2000, cc. 675, 700; 2016, c. 588.

§ 32.1-162.24. Duties of the Board.

The Board shall:

1. Establish specific criteria and procedures governing its decisions to support research efforts consistent with its purposes, including (i) encouraging collaborative research efforts among two or more institutions or organizations, (ii) giving priority to those research efforts from which Board support can be leveraged to foster contributions from federal agencies or other entities, and (iii) supporting both new research efforts and the expansion or continuation of existing research efforts;

2. Establish requirements for the submission of research proposals, including (i) a clear statement of the problem or opportunity to be addressed; (ii) the specific objectives; (iii) a description of how the results will maximize human health benefits for the citizens of the Commonwealth; (iv) a budget for the research effort, including other anticipated sources of financial assistance; and (v) the timeframe for conducting the research;

3. Evaluate the proposals in accordance with the criteria established by the Board and the provisions of this chapter; and

4. Evaluate the implementation and results of all research efforts receiving support from the Board.

1997, cc. 803, 888, 891, § 23-279; 2016, c. 588.

§ 32.1-162.25. Powers of the Board.

In order to carry out its purposes, the Board may:

1. Make grants and disbursements from the Fund that support research efforts approved by the Board in accordance with the purposes of this chapter and pay expenditures from the Fund that are necessary to carry out the purposes of this chapter. The Board is not obligated to make annual or other periodic disbursements or expenditures;

2. Contract for the services of consultants to review research proposals and assist in the evaluation of the research efforts funded by the Board;

3. Contract for other professional services to assist the Board in the performance of its duties and responsibilities;

4. Accept, hold, administer, and solicit gifts, grants, bequests, contributions, or other assistance from federal agencies, the Commonwealth, or any other public or private source to carry out the purposes of this chapter;

5. Enter into any agreement or contract relating to the acceptance or use of any grant, assistance, or support provided by or to the Board or otherwise in furtherance of the purposes of this chapter;

6. Perform any lawful acts necessary or appropriate to carry out the purposes of the Board; and

7. Employ such staff as is necessary to perform the Board's duties. The Board may determine the duties of such staff and fix the salaries and compensation of such staff, which shall be paid from the Fund. Such staff are employees of the Department of Accounts and are entitled to all benefits available to state employees as provided by law.

1997, cc. 803, 888, 891, § 23-281; 2000, cc. 675, 700; 2002, cc. 591, 612; 2012, cc. 682, 683; 2016, c. 588.

§ 32.1-162.26. Conditions and restrictions on financial assistance.

A. The Board shall provide financial support only for research efforts that satisfy the following conditions:

1. The research shall be conducted by public institutions of higher education, agencies of the Commonwealth, or nonprofit organizations exempt from income taxation pursuant to § 501(c)(3) of the Internal Revenue Code and located in the Commonwealth;

2. The institution, agency, or organization shall match a percentage of the Board's support in a cash amount required by the Board;

3. No support provided by the Board shall be used by the recipient to finance capital improvements or renovations, for indirect costs incurred by the institution, agency, or organization in its administration of the financial support, or for any other purpose proscribed by the Board; and

4. Recipients of support provided by the Board shall agree to provide the Board with such information regarding the implementation of the research effort and allow such monitoring and review of the research effort as may be required by the Board to ensure compliance with the terms under which the support is provided.

B. Any support provided by the Board shall be used by the recipient only for personal services, contractual services, material, supplies, and equipment directly relating to the approved research effort.

1997, cc. 803, 888, 891, § 23-280; 2016, c. 588.

§ 32.1-162.27. Cooperation with other agencies.

All agencies of the Commonwealth shall cooperate with the Board and, upon request, assist the Board in the performance of its duties and responsibilities.

1997, cc. 803, 888, 891, § 23-283; 2016, c. 588.

§ 32.1-162.28. Commonwealth Health Research Fund established; administration.

A. There is created in the state treasury a special nonreverting fund to be known as the Commonwealth Health Research Fund. The Fund shall be established on the books of the Comptroller.

B. The Fund shall consist of all stock and cash distributed to the Commonwealth as a policyholder pursuant to the conversion of Blue Cross and Blue Shield of Virginia, doing business as Trigon Blue Cross Blue Shield, from a mutual insurance company to a Virginia stock corporation known as Trigon Healthcare, Inc., exclusive of cash paid by Blue Cross and Blue Shield of Virginia or its successor to the Commonwealth in connection with such conversion, which was assumed as general fund revenue in Chapter 912 of the Acts of Assembly of 1996. The Fund shall also consist of any moneys appropriated from the general fund, grants and donations received by the Board, and other moneys received by the State Treasurer and designated for deposit in the Fund. Interest and other income earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund,

including interest and other income thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

C. Notwithstanding any other provision of law, the moneys and other property constituting the Fund shall be invested, reinvested, and managed by the Board of the Virginia Retirement System as provided in § 51.1-124.36. The State Treasurer is not liable for losses suffered by the Virginia Retirement System on investments made under the authority of this section.

D. Moneys in the Fund shall be expended solely for the purpose of supporting research efforts approved by the Board and any other purpose permitted by this chapter.

E. An amount not to exceed six percent of the moving average of the market value of the Fund calculated over the previous five years or since inception, whichever is shorter, on a one-year delayed basis, net of any administrative fee assessed pursuant to subsection E of § 51.1-124.36, may be expended in a calendar year for any purpose permitted by this chapter. The Board is not required to expend such amount in a calendar year, and any amount up to such six percent that is not expended in a calendar year may be expended in any other calendar year.

F. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the chairman of the Board.

1997, cc. 803, 888, 891, § 23-284; 2000, cc. 675, 700; 2002, cc. 591, 612; 2013, c. 687; 2016, c. 588.

§ 32.1-162.29. Form and audit of accounts and records.

A. The accounts and records of the Board showing the receipt and disbursement of funds from whatever source derived shall be in such form as the Auditor of Public Accounts prescribes.

B. The accounts and records of the Board are subject to an annual audit by the Auditor of Public Accounts or his legal representative.

1997, cc. 803, 888, 891, § 23-285; 2016, c. 588.

§ 32.1-162.30. Annual report.

The Board shall submit to the Governor and the General Assembly an annual executive summary of the interim activity and work of the Board no later than the first day of each regular session of the General Assembly. The executive summary shall be submitted as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports and shall be posted on the General Assembly's website. The executive summary shall include information regarding research efforts supported by the Board and expenditures from the Fund.

1997, cc. 803, 888, 891, § 23-286; 2016, c. 588.

§ 32.1-162.31. Christopher Reeve Stem Cell Research Fund.

A. From such funds as may be appropriated by the General Assembly and any gifts, grants, or donations from public or private sources, there is created in the state treasury a special, nonreverting, revolving, and permanent fund to be known as the Christopher Reeve Stem Cell Research Fund. The

Christopher Reeve Stem Cell Research Fund shall be established on the books of the Comptroller and shall be administered and implemented by the Board in accordance with the provisions of this section. Interest earned on moneys in the Christopher Reeve Stem Cell Research Fund shall remain in the Christopher Reeve Stem Cell Research Fund and be credited to it. Any moneys remaining in the Christopher Reeve Stem Cell Research Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Christopher Reeve Stem Cell Research Fund. Expenditures and disbursements from the Christopher Reeve Stem Cell Research Fund, which may consist of grants, donations, or other assistance, shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the chairman or vice-chairman of the Board.

B. Moneys in the Christopher Reeve Stem Cell Research Fund shall be used solely to support medical and biomedical stem cell research conducted in institutions of higher education in the Commonwealth that relates to the causes and cures of disease, including paralysis caused by spinal cord injury, diabetes, cancer, heart disease, and neurological disorders such as amyotrophic lateral sclerosis (Lou Gehrig's disease) and multiple sclerosis.

C. The grants, donations, or other assistance provided pursuant to this section shall be awarded in accordance with the Board's specific criteria and procedures, requirements for submission of research proposals, and evaluation mechanisms established pursuant to this chapter. However, no requirement for matching funds shall apply to the grants, donations, or other assistance awarded pursuant to the Christopher Reeve Stem Cell Research Fund, and the leveraging of funds is incidental to the support provided under this section. The grants, donations, or other assistance provided pursuant to this section may be awarded to support stem cell research that is not eligible for federal research funds through the National Institutes of Health. No moneys from the Christopher Reeve Stem Cell Research Fund may be provided to any entity that conducts human stem cell research from stem cells obtained from human embryos or for conducting such research; however, research conducted using stem cells other than embryonic stem cells may be funded.

2005, c. 696, § 23-286.1; 2016, c. 588.

Chapter 5.4 - Animal Research

§ 32.1-162.32. Definitions.

A. For purposes of this section, unless the context requires a different meaning:

"Animal subject" means a dog or a cat.

"Medically unnecessary" means not carried out solely for the better health, welfare, or safety of the animal subject.

B. No funds appropriated, granted, or awarded by the Commonwealth shall be used by any person or entity, public or private, to directly fund medically unnecessary research classified under pain and distress category E by the U.S. Department of Agriculture on animal subjects. For purposes of this

section, the direct funding of research shall not include the appropriation, grant, or award of funds for the construction or maintenance of facilities; the purchase or maintenance of general-use equipment; overhead costs; capital improvements; or faculty or employee salaries.

2018, c. 771.

Chapter 6 - Environmental Health Services

Article 1 - SEWAGE DISPOSAL

§ 32.1-163. Definitions.

As used in this article, unless the context clearly requires a different meaning:

"Alternative discharging sewage system" means any device or system which results in a point source discharge of treated sewage for which the Board may issue a permit authorizing construction and operation when such system is regulated by the State Water Control Board pursuant to a general Virginia Pollutant Discharge Elimination System permit issued for an individual single family dwelling with flows less than or equal to 1,000 gallons per day.

"Alternative onsite sewage system" or "alternative onsite system" means a treatment works that is not a conventional onsite sewage system and does not result in a point source discharge.

"Betterment loan" means a loan to be provided by private lenders either directly or through a state agency, authority or instrumentality or a locality or local or regional authority serving as a conduit lender, to repair, replace, or upgrade an onsite sewage system or an alternative discharging sewage system for the purpose of reducing threats to public health and ground and surface waters, which loan is secured by a lien with a priority equivalent to the priority of a lien securing an assessment for local improvements under § 15.2-2411.

"Conduit lender" means a state agency, authority or instrumentality or a locality, local or regional authority or an instrumentality thereof serving as a conduit lender of betterment loans.

"Conventional onsite sewage system" means a treatment works consisting of one or more septic tanks with gravity, pumped, or siphoned conveyance to a gravity distributed subsurface drainfield.

"Licensed onsite soil evaluator" means a person who is licensed under Chapter 23 (§ 54.1-2300 et seq.) of Title 54.1 as an onsite soil evaluator. A licensed onsite soil evaluator is authorized to evaluate soils and soil properties in relationship to the effects of these properties on the use and management of these soils as the locations for onsite sewage systems.

"Maintenance" means, unless otherwise provided in local ordinance, (i) performing adjustments to equipment and controls or (ii) in-kind replacement of normal wear and tear parts that do not require a construction permit for adjustment or replacement of the component such as light bulbs, fuses, filters, pumps, motors, sewer lines, conveyance lines, distribution boxes, header lines, or other like components. "Maintenance" includes pumping the tanks or cleaning the building sewer on a periodic basis. Notwithstanding any local ordinance, "maintenance" does not include replacement of tanks,

drainfield piping, subsurface drainfields, or work requiring a construction permit and installer. Unless otherwise prohibited by local ordinance, a conventional onsite sewage system installer or an alternative onsite sewage system installer may perform maintenance work limited to in-kind replacement of light bulbs, fuses, filters, pumps, sewer lines, conveyance lines, distribution boxes, and header lines.

"Operate" means the act of making a decision on one's own volition (i) to place into or take out of service a unit process or unit processes or (ii) to make or cause adjustments in the operation of a unit process at a treatment works.

"Operation" means the biological, chemical, and mechanical processes of transforming sewage or wastewater to compounds or elements and water that no longer possess an adverse environmental or health impact.

"Operator" means any individual employed or contracted by any owner, who is licensed or certified under Chapter 23 (§ 54.1-2300 et seq.) of Title 54.1 as being qualified to operate, monitor, and maintain an alternative onsite sewage system.

"Owner" means the Commonwealth or any of its political subdivisions, including sanitary districts, sanitation district commissions and authorities, any individual, any group of individuals acting individually or as a group, or any public or private institution, corporation, company, partnership, firm or association which owns or proposes to own a sewerage system or treatment works.

"Regulations" means the Sewage Handling and Disposal Regulations, heretofore or hereafter enacted or adopted by the State Board of Health.

"Review Board" means the State Sewage Handling and Disposal Appeals Review Board.

"Sewage" means water-carried and non-water-carried human excrement, kitchen, laundry, shower, bath or lavatory wastes, separately or together with such underground, surface, storm and other water and liquid industrial wastes as may be present from residences, buildings, vehicles, industrial establishments or other places.

"Sewerage system" means pipelines or conduits, pumping stations and force mains and all other construction, devices and appliances appurtenant thereto, used for the collection and conveyance of sewage to a treatment works or point of ultimate disposal.

"Subsurface drainfield" means a system installed within the soil and designed to accommodate treated sewage from a treatment works.

"Transportation" means the vehicular conveyance of sewage.

"Treatment works" means any device or system used in the storage, treatment, disposal or reclamation of sewage or combinations of sewage and industrial wastes, including but not limited to pumping, power and other equipment and appurtenances, septic tanks, and any works, including land, that are or will be (i) an integral part of the treatment process or (ii) used for ultimate disposal of residues or effluents resulting from such treatment.

Code 1950, § 32-9; 1954, c. 646; 1964, c. 436; 1970, c. 645; 1972, c. 775; 1979, c. 711; 1984, c. 457; 1990, cc. 342, 861, 869; 1994, c. 747; 2007, cc. 892, 924; 2009, c. 829; 2018, c. 830.

§ 32.1-163.1. Personal liability of sanitarians defined.

A sanitarian while acting within the scope of his employment in approving or denying applications for permits for onsite sewage disposal systems or while performing checks of or reviewing and approving field evaluations completed by licensed onsite soil evaluators shall be subject to personal liability only for his gross negligence or intentional misconduct.

1986, c. 331; 1994, c. 747; 2016, c. 90.

§ 32.1-163.2. Long range plan for onsite sewage.

In addition to the powers and duties provided in § 32.1-164, the Board of Health shall develop and revise as may be necessary a five-year plan for the handling and disposal of onsite sewage. Such plan shall include (i) the number of applications for onsite sewage permits per year; (ii) the number of households or facilities utilizing onsite sewage systems per year; (iii) the volume of onsite sewage to be disposed per year; (iv) the available and needed capacity in the Commonwealth for environmentally sound methods of disposal of septage in sewage treatment plants, other approved facilities and by land application per year; (v) descriptions of technology for alternative systems including the types of soils and conditions recommended as appropriate for such alternative systems; and (vi) recommendations for changes in the laws or regulations pertaining to onsite sewage and the system of permitting onsite sewage systems. The Board shall also report every five years to the governor and the General Assembly, beginning in 1992, on the status of onsite sewage handling and disposal in Virginia and the progress in implementing its long range plan.

1987, c. 223.

§ 32.1-163.3. Identities of persons making certain reports to remain confidential.

The identity of any person making a report of an alleged violation of any provision of this article or any regulation of the Board of Health relating to sewage disposal shall be confidential. However, the identity of such person may be disclosed (i) to the Commissioner, the members of the Board and personnel of the Department in the performance of their duties; (ii) when the identity is included in materials which are the subject of a request for information pursuant to the Virginia Freedom of Information Act, Chapter 37 (§ 2.2-3700 et seq.) of Title 2.2; (iii) when the matter reported is the subject of a hearing conducted by the State Health Department Sewage Handling and Disposal Appeal Review Board; or (iv) when the matter reported is the subject of litigation.

1990, c. 468.

§ 32.1-163.4. Procedures for application backlogs; individuals approved to conduct evaluations for septic system or other onsite sewage system permit applications.

A. In any case where the local or district health department experiences a septic system or other onsite sewage system permit backlog of 15 working days from the application filing date, the Commissioner shall contract with licensed onsite soil evaluators for the field evaluation of the backlogged

application sites. The Department shall review these evaluations and may approve the permit applications upon finding that the evaluations are in compliance with the Board's regulations implementing this chapter. The Department shall not be required to do a field check of the evaluation prior to issuing the permit; however, the Department may conduct such field analyses as deemed necessary to protect the integrity of the Commonwealth's environment.

B. The Board, Commissioner, and Department of Health shall accept private evaluations for septic system or other onsite sewage system permit applications only from licensed onsite soil evaluators.

C. The Board's regulations shall include a definition of backlog providing a set number or a percent of the received applications.

1994, c. 747; 2016, c. 90.

§ 32.1-163.5. Onsite sewage evaluations.

A. Notwithstanding other provisions of this chapter, for purposes of subdivision review, permit approval, and issuance of letters for residential development, the Board, Commissioner, and Department of Health shall accept private site evaluations and designs, in compliance with the Board's regulations for septic systems and other onsite sewage systems, designed and certified by a licensed professional engineer, in consultation with a licensed onsite soil evaluator, or by a licensed onsite soil evaluator. The evaluations and designs included within such submissions shall be certified as complying with the Board's regulations implementing this chapter.

B. The Department shall not be required to perform a field check of private evaluations and designs prior to issuing the requested letter, permit or approval; however, the Department may conduct such review of the work and field analysis as deemed necessary to protect the public health and integrity of the Commonwealth's environment. Within 15 working days from the date of written submission of a request for approval of a site evaluation and design for a single lot construction permit, and within 60 days from the date of written submission of a request for approval of a site evaluation and design for multiple lot certification letters or subdivision review, the Department shall (i) issue the requested letter, permit or approval or (ii) set forth in writing the specific reasons for denial. If the Department fails to take action to approve or disapprove the designs, evaluations, or subdivision reviews within the time specified herein, the designs, evaluations or subdivision reviews shall be deemed approved and the appropriate letter, permit or approval shall be issued. Notwithstanding any other provision of law or the provisions of any local ordinance, counties, cities and towns shall comply with the time limits set forth in this subsection.

C. Nothing in this section shall authorize anyone other than an individual licensed as a professional engineer pursuant to Chapter 4 (§ 54.1-400 et seq.) of Title 54.1 to engage in the practice of engineering.

D. The provisions of this section shall not apply to any locality that has entered into a contract with the Board of Health in accordance with Chapter 678 of the 1994 Acts of Assembly nor to a proprietary, pre-engineered septic system deemed by the Department to comply with the Board's regulations.

1999, c. 1038; 2001, c. 337; 2016, c. 90.

§ 32.1-163.6. Professional engineering of onsite treatment works.

A. Notwithstanding other provisions of this chapter, for purposes of permit approval, the Board, Commissioner, and Department of Health shall accept treatment works designs from individuals licensed as professional engineers pursuant to Chapter 4 (§ 54.1-400 et seq.) of Title 54.1. The designs shall (i) be compliant with standard engineering practice and performance requirements established by the Board and those horizontal setback requirements necessary to protect the public health and the environment, (ii) reflect that degree of skill and care ordinarily exercised by licensed members of the engineering profession practicing at the time of performance, (iii) be appropriate for the particular soil characteristics of the site, and (iv) ensure that the treatment works will meet or exceed the discharge, effluent, and surface and ground water quality standards for systems otherwise permitted pursuant to the regulations implementing this chapter.

B. The Department may conduct such review of the work and field analysis as deemed necessary to protect the public health and integrity of the Commonwealth's environment.

C. Within 21 calendar days from the date of application for treatment works sized at 1,000 gallons per day or smaller, and within 60 calendar days from the date of application for treatment works sized at more than 1,000 gallons per day, the Department shall (i) issue the requested approval, or (ii) set forth in writing the specific reasons for denial.

D. The Department shall establish an engineering design review panel to review the Department's decision to disapprove an onsite sewage system design. The Commissioner shall appoint four individuals licensed as professional engineers pursuant to Chapter 4 (§ 54.1-400 et seq.) of Title 54.1 with expertise in onsite sewage systems to serve on the engineering design review panel with (i) one representing the Department of Health, (ii) one representing the Department of Environmental Quality, (iii) one representing the Virginia Society of Professional Engineers, and (iv) one representing the American Council of Engineering Companies of Virginia. If a state agency is unable to provide a representative in accordance with this subsection, the Commissioner shall appoint another individual licensed as a professional engineer pursuant to Chapter 4 (§ 54.1-400 et seq.) of Title 54.1 with expertise in onsite sewage systems. The members of the design review panel shall appoint a member to serve as Chairman. The design review panel shall be designated a subordinate, as defined in § 2.2-4001, and shall meet as necessary.

E. When the Department denies an application pursuant to subsection D, the owner may appeal that decision in accordance with § 32.1-164.1. Alternatively, the owner, or the professional engineer responsible for an onsite sewage system design with the owner's written consent, may request an informal fact-finding conference before the engineering design review panel established in subsection D. The request must (i) be in writing, (ii) be received by the Commissioner within 30 days of the professional engineer's receipt of the Department's denial, and (iii) cite the reason or reasons for the request. The informal fact-finding conference shall be held within 45 calendar days of the request. The

proceedings of the engineering design review panel shall be governed by the provisions of the Administrative Process Act (§ 2.2-4000 et seq.). Within 30 days following its receipt of the engineering review panel's written recommendations, the Department shall consider the recommendations of the engineering design review panel and approve the application or re-affirm its denial.

F. When the Department denies an application following review by the engineering design review panel, the owner may appeal that decision in accordance with § 32.1-164.1.

G. This section shall not be construed to require an owner to seek review by the engineering design review panel before appealing a permit denial pursuant to § 32.1-164.1.

H. This section shall not be construed to prohibit any locality from adopting or enforcing any ordinance duly enacted pursuant to Chapter 21 (§ 15.2-2100 et seq.) of Title 15.2.

I. All treatment works designs permitted pursuant to this section shall comply with operation, maintenance, and monitoring requirements as set forth in regulations implementing this chapter.

2008, c. 515; 2009, cc. 97, 220, 296.

§ 32.1-164. Powers and duties of Board; regulations; fees; onsite soil evaluators; letters in lieu of permits; inspections; civil penalties.

A. The Board shall have supervision and control over the safe and sanitary collection, conveyance, transportation, treatment, and disposal of sewage by onsite sewage systems and alternative discharging sewage systems, and treatment works as they affect the public health and welfare. The Board shall also have supervision and control over the maintenance, inspection, and reuse of alternative onsite sewage systems as they affect the public health and welfare. In discharging the responsibility to supervise and control the safe and sanitary treatment and disposal of sewage as they affect the public health and welfare, the Board shall exercise due diligence to protect the quality of both surface water and ground water. Upon the final adoption of a general Virginia Pollutant Discharge Elimination permit by the State Water Control Board, the Board of Health shall assume the responsibility for permitting alternative discharging sewage systems as defined in § 32.1-163. All such permits shall comply with the applicable regulations of the State Water Control Board and be registered with the State Water Control Board.

In the exercise of its duty to supervise and control the treatment and disposal of sewage, the Board shall require and the Department shall conduct regular inspections of alternative discharging sewage systems. The Board shall also establish requirements for maintenance contracts for alternative discharging sewage systems. The Board may require, as a condition for issuing a permit to operate an alternative discharging sewage system, that the applicant present an executed maintenance contract. Such contract shall be maintained for the life of any general Virginia Pollutant Discharge Elimination System permit issued by the State Water Control Board.

B. The regulations of the Board shall govern the collection, conveyance, transportation, treatment and disposal of sewage by onsite sewage systems and alternative discharging sewage systems and the

maintenance, inspection, and reuse of alternative onsite sewage systems. Such regulations shall be designed to protect the public health and promote the public welfare and may include, without limitation:

1. A requirement that the owner obtain a permit from the Commissioner prior to the construction, installation, modification or operation of a sewerage system or treatment works except in those instances where a permit is required pursuant to Chapter 3.1 (§ 62.1-44.2 et seq.) of Title 62.1.

2. Criteria for the granting or denial of such permits.

3. Standards for the design, construction, installation, modification and operation of sewerage systems and treatment works for permits issued by the Commissioner.

4. Standards governing disposal of sewage on or in soils.

5. Standards specifying the minimum distance between sewerage systems or treatment works and:

a. Public and private wells supplying water for human consumption,

b. Lakes and other impounded waters,

c. Streams and rivers,

d. Shellfish waters,

e. Ground waters,

f. Areas and places of human habitation,

g. Property lines.

6. Standards as to the adequacy of an approved water supply.

7. Standards governing the transportation of sewage.

8. A prohibition against the discharge of untreated sewage onto land or into waters of the Commonwealth.

9. A requirement that such residences, buildings, structures and other places designed for human occupancy as the Board may prescribe be provided with a sewerage system or treatment works.

10. Criteria for determining the demonstrated ability of alternative onsite systems, which are not permitted through the then current sewage handling and disposal regulations, to treat and dispose of sewage as effectively as approved methods.

11. Standards for inspections of and requirements for maintenance contracts for alternative discharging sewage systems.

12. Notwithstanding the provisions of subdivision 1 above and Chapter 3.1 of Title 62.1, a requirement that the owner obtain a permit from the Commissioner prior to the construction, installation, modification, or operation of an alternative discharging sewage system as defined in § 32.1-163.

13. Criteria for granting, denying, and revoking of permits for alternative discharging sewage systems.

14. Procedures for issuing letters recognizing onsite sewage sites in lieu of issuing onsite sewage system permits.

15. Performance requirements for nitrogen discharged from alternative onsite sewage systems that protect public health and ground and surface water quality.

16. Consideration of the impacts of climate change on proposed treatment works based on research and analysis from the Center for Coastal Resources Management at the Virginia Institute of Marine Science at The College of William and Mary in Virginia.

C. A fee of $75 shall be charged for filing an application for an onsite sewage system or an alternative discharging sewage system permit with the Department. Funds received in payment of such charges shall be transmitted to the Comptroller for deposit. The funds from the fees shall be credited to a special fund to be appropriated by the General Assembly, as it deems necessary, to the Department for the purpose of carrying out the provisions of this title. However, $10 of each fee shall be credited to the Onsite Sewage Indemnification Fund established pursuant to § 32.1-164.1:01.

The Board, in its regulations, shall establish a procedure for the waiver of fees for persons whose incomes are below the federal poverty guidelines established by the United States Department of Health and Human Services or when the application is for a pit privy or the repair of a failing onsite sewage system. If the Department denies the permit for land on which the applicant seeks to construct his principal place of residence, then such fee shall be refunded to the applicant.

From such funds as are appropriated to the Department from the special fund, the Board shall apportion a share to local or district health departments to be allocated in the same ratios as provided for the operation of such health departments pursuant to § 32.1-31. Such funds shall be transmitted to the local or district health departments on a quarterly basis.

D. In addition to factors related to the Board's responsibilities for the safe and sanitary treatment and disposal of sewage as they affect the public health and welfare, the Board shall, in establishing standards, give due consideration to economic costs of such standards in accordance with the applicable provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

E. Further a fee of $75 shall be charged for such installation and monitoring inspections of alternative discharging sewage systems as may be required by the Board. The funds received in payment of such fees shall be credited to a special fund to be appropriated by the General Assembly, as it deems necessary, to the Department for the purpose of carrying out the provisions of this section. However, $10 of each fee shall be credited to the Onsite Sewage Indemnification Fund established pursuant to § 32.1-164.1:01.

The Board, in its regulations, shall establish a procedure for the waiver of fees for persons whose incomes are below the federal poverty guidelines established by the United States Department of Health and Human Services.

F. Any owner who violates any provision of this section or any regulation of the Board of Health or the State Water Control Board relating to alternative discharging sewage systems or who fails to comply with any order of the Board of Health or any special final order of the State Water Control Board shall be subject to the penalties provided in §§ 32.1-27 and 62.1-44.32.

In the event that a county, city, or town, or its agent, is the owner, the county, city, or town, or its agent may initiate a civil action against any user or users of an alternative discharging sewage system to recover that portion of any civil penalty imposed against the owner which directly resulted from violations by the user or users of any applicable federal, state, or local laws, regulations, or ordinances.

G. The Board shall establish and implement procedures for issuance of letters recognizing the appropriateness of onsite sewage site conditions in lieu of issuing onsite sewage system permits. The Board may require that a survey plat be included with an application for such letter. Such letters shall state, in language determined by the Office of the Attorney General and approved by the Board, the appropriateness of the soil for an onsite sewage system; no system design shall be required for issuance of such letter. The letter may be recorded in the land records of the clerk of the circuit court in the jurisdiction where all or part of the site or proposed site of the onsite sewage system is to be located so as to be a binding notice to the public, including subsequent purchases of the land in question. Upon the sale or transfer of the land which is the subject of any letter, the letter shall be transferred with the title to the property. A permit shall be issued on the basis of such letter unless, from the date of the letter's issuance, there has been a substantial, intervening change in the soil or site conditions where the onsite sewage system is to be located. The Board, Commissioner, and the Department shall accept evaluations from licensed onsite soil evaluators for the issuance of such letters, if they are produced in accordance with the Board's established procedures for issuance of letters. The Department shall issue such letters within 20 working days of the application filing date when evaluations produced by licensed onsite soil evaluators are submitted as supporting documentation. The Department shall not be required to do a field check of the evaluation prior to issuing such a letter or a permit based on such letter; however, the Department may conduct such field analyses as deemed necessary to protect the integrity of the Commonwealth's environment. Applicants for such letters in lieu of onsite sewage system permits shall pay the fee established by the Board for the letters' issuance and, upon application for an onsite sewage system permit, shall pay the permit application fee.

H. The Board shall establish a program for the operation and maintenance of alternative onsite systems. The program shall require:

1. The owner of an alternative onsite sewage system, as defined in § 32.1-163, to have that system operated by a licensed operator, as defined in § 32.1-163, and visited by the operator as specified in the operation permit;

2. The licensed operator to provide a report on the results of the site visit utilizing the web-based system required by this subsection. A fee of $1 shall be paid by the licensed operator at the time the

report is filed. Such fees shall be credited to the Onsite Operation and Maintenance Fund established pursuant to § 32.1-164.8;

3. A statewide web-based reporting system to track the operation, monitoring, and maintenance requirements of each system, including its components. The system shall have the capability for pre-notification of operation, maintenance, or monitoring to the operator or owner. Licensed operators shall be required to enter their reports onto the system. The Department of Health shall utilize the system to provide for compliance monitoring of operation and maintenance requirements throughout the state. The Commissioner shall consider readily available commercial systems currently utilized within the Commonwealth; and

4. Any additional requirements deemed necessary by the Board.

I. The Board shall promulgate regulations governing the requirements for maintaining alternative onsite sewage systems.

J. The Board shall establish a uniform schedule of civil penalties for violations of (i) regulations promulgated pursuant to subsection B and (ii) onsite treatment system pump-out requirements promulgated pursuant to the Chesapeake Bay Preservation Act (§ 62.1-44.15:67 et seq.) in localities in which compliance with such onsite treatment system pump-out requirements is managed and enforced by the Department that are not remedied within 30 days after service of notice from the Department. Civil penalties collected pursuant to this chapter shall be credited to the Environmental Health Education and Training Fund established pursuant to § 32.1-248.3.

This schedule of civil penalties shall be uniform for each type of specified violation, and the penalty for any one violation shall be not more than $100 for the initial violation and not more than $150 for each additional violation. Each day during which the violation is found to have existed shall constitute a separate offense. However, specified violations arising from the same operative set of facts shall not be charged more than once in any 10-day period, and a series of specified violations arising from the same operative set of facts shall not result in civil penalties exceeding a total of $3,000. Penalties shall not apply to unoccupied structures which do not contribute to the pollution of public or private water supplies or the contraction or spread of infectious, contagious, or dangerous diseases. The Department may pursue other remedies as provided by law; however, designation of a particular violation for a civil penalty pursuant to this section shall be in lieu of criminal penalties, except for any violation that contributes to or is likely to contribute to the pollution of public or private water supplies or the contraction or spread of infectious, contagious, or dangerous diseases.

The Department may issue a civil summons ticket as provided by law for a scheduled violation. Any person summoned or issued a ticket for a scheduled violation may make an appearance in person or in writing by mail to the Department prior to the date fixed for trial in court. Any person so appearing may enter a waiver of trial, admit liability, and pay the civil penalty established for the offense charged.

If a person charged with a scheduled violation does not elect to enter a waiver of trial and admit liability, the violation shall be tried in the general district court with jurisdiction in the same manner and

with the same right of appeal as provided for by law. In any trial for a scheduled violation, the Department shall have the burden of proving by a preponderance of the evidence the liability of the alleged violator. An admission of liability or finding of liability under this section shall not be deemed an admission at a criminal proceeding.

This section shall not be interpreted to allow the imposition of civil penalties for activities related to land development.

K. The Department shall establish procedures for requiring a survey plat as part of an application for a permit or letter for any onsite sewage or alternative discharging sewage system, and for granting waivers for such requirements. In all cases, it shall be the landowner's responsibility to ensure that the system is properly located as permitted.

L. Effective July 1, 2023, requirements promulgated under the Chesapeake Bay Preservation Act (§ 62.1-44.15:67 et seq.) directly related to compliance with onsite sewage treatment system pump-outs shall be managed and enforced by the Department in Accomack, Essex, Gloucester, King and Queen, King William, Lancaster, Mathews, Middlesex, Northampton, Northumberland, Richmond, and Westmoreland Counties, and the incorporated towns within those counties. Licensed operators conducting onsite sewage treatment system pump-outs pursuant to requirements promulgated under the Chesapeake Bay Preservation Act (§ 62.1-44.15:67 et seq.) in localities managed and enforced by the Department shall provide a report on the results of the site visit using a web-based reporting system developed by the Department. Any person who violates the onsite treatment system pump-out requirements promulgated pursuant to the Chesapeake Bay Preservation Act (§ 62.1-44.15:67 et seq.) in a locality in which compliance with such onsite treatment system pump-out requirements is managed and enforced by the Department is guilty of a Class 3 misdemeanor.

Code 1950, § 32-9; 1954, c. 646; 1964, c. 436; 1970, c. 645; 1972, c. 775; 1979, c. 711; 1986, c. 401; 1988, c. 203; 1990, cc. 438, 861, 869; 1994, c. 747; 1999, c. 871; 2003, c. 614; 2007, cc. 514, 892, 924; 2009, cc. 695, 747; 2021, Sp. Sess. I, c. 382; 2022, c. 486.

§ 32.1-164.1. Appeals from denials of septic tank permits; inspections.

A. Whenever administrative action is taken to deny a septic tank permit or to grant a septic tank permit with conditions or to refuse to issue, or grant with conditions, a letter recognizing the appropriateness of onsite sewage site conditions in lieu of issuing an onsite sewage system permit, the applicant shall be advised in writing of the administrative remedies that are available to obtain a reversal of the denial or refusal or a modification or elimination of the conditions, or, if no further administrative remedies are available, of the right of appeal provided for hereinafter. After exhausting his administrative remedies, as set forth in § 32.1-164.1:1 et seq., any person aggrieved by a case decision of the Review Board shall have the right to judicial review in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

The decision may be recorded in the land records of the clerk of the circuit court in the jurisdiction where all or part of the site or proposed site of the septic system is located so as to be binding notice to the public, including subsequent purchases of the land in question.

B. The holder of any permit for a septic tank issued with conditions shall have the permit recorded in the land records of the clerk of the circuit court having jurisdiction over the site of the septic system. The holder of the permit and any subsequent holders of the permit through land purchase or transfer shall be bound by the conditions stated in the permit unless the holder or subsequent holder obtains an additional permit for modification or alteration of the septic system to meet any new use conditions.

C. In adopting regulations prescribing criteria for the granting or denial of permits for septic tanks, the Board shall consider varying circumstances such as population density, extent of use of the septic tank and such other circumstances as may affect the stringency of the criteria necessary to protect the public health and promote the general welfare and may provide for the issuance of permits for septic tanks subject to such conditions as may be necessary to protect the public health.

D. Upon receipt of an application for a septic tank permit or a letter recognizing the appropriateness of onsite sewage site conditions in lieu of issuing onsite sewage system permits, the local health department shall notify the governing body of the county or city where the septic tank will be located or the official designated by the governing body for that purpose and shall provide such information concerning the application and the actions taken on the application as the governing body or officer may request.

E. Whenever a construction permit has been issued pursuant to an evaluation and design certified by a licensed professional engineer or onsite soil evaluator, the certifying licensed professional engineer or onsite soil evaluator shall inspect that system at the time of installation and provide an inspection report to the Department. The Department may, but is not required to, inspect the installation of such onsite sewage system. In the event that the certifying licensed professional engineer or onsite soil evaluator does not inspect the system in a timely manner or declines to certify that the installation was completed substantially in accordance with the evaluation and design, the owner may petition the Department to inspect the installation and render a final case decision approving or disapproving the installation. The Department shall not be required to convene an informal fact finding proceeding in accordance with § 2.2-4019 prior to rendering such decision.

Code 1950, § 32-9.01; 1979, c. 497; 1980, c. 503; 1984, cc. 457, 548; 1986, c. 615; 1994, c. 747; 2012, c. 184.

§ 32.1-164.1:01. Onsite Sewage Indemnification Fund.

A. There is hereby created the Onsite Sewage Indemnification Fund, hereafter referred to as "the Fund," whose purpose is to receive moneys generated by a portion of the fees collected by the Department of Health pursuant to subsections C and E of § 32.1-164 and appropriated by the Commonwealth for the purpose of assisting any Virginia real property owner holding a valid permit to operate an onsite sewage system when such system or components thereof fail within three years of

construction and such failure results from the negligence of the Department of Health. The Fund may also be used, in the discretion of the Board, to support the program for training and recognition of licensed onsite soil evaluators and to provide grants and loans to property owners with income at or below 200 percent of the federal poverty guidelines to repair failing onsite sewage systems or install onsite sewage systems on properties that lack adequate sewage disposal. No expenses shall be paid from the Fund to support the program for training and recognition of onsite soil evaluators, or to provide any grant or loan to repair a failing onsite sewage system or install an onsite sewage system on any property that lacks adequate sewage disposal, in lieu of payment to any owner or owners qualified to receive payment from the Fund pursuant to this chapter.

B. Ten dollars of each fee collected by the Department of Health pursuant to subsections C and E of § 32.1-164 shall be deposited by the Comptroller in the Fund to be appropriated for the purposes of this section to the Department of Health by the General Assembly as it deems necessary.

C. The owner of an onsite sewage system that has been permitted by the Department of Health may cause, by filing a request for payment from the Fund within one year from the date the system or components thereof failed, the Commissioner to review the circumstances of the onsite sewage system failure, if the onsite sewage system has failed within three years of construction. Upon the Commissioner's finding that the onsite sewage system was permitted by the Department and (i) the system or components thereof failed within three years of construction; (ii) that specific actions of the Department were negligent and that those actions caused the failure; and (iii) that the owner filed a request for payment from the Fund within one year from the date the system or components thereof failed, the Commissioner shall, subject to the limitations stated herein, reimburse the owner for the reasonable cost of following the Board's regulations to repair or replace the failed onsite sewage system or components thereof.

D. Prior to receiving payment from the Fund, the owner shall follow the requirements in the Board's regulations to repair or replace the failed onsite sewage system or components thereof.

E. The total amount an owner may receive in payment from the Fund shall not exceed $30,000. Only the costs of the system that failed or the costs of labor and equipment required to repair or replace the failed onsite sewage system or components thereof are reimbursable by the Fund.

F. If the Commissioner finds that the system was permitted by the Department and has failed within three years of construction and that the failure resulted from faulty construction or other private party error, the Commissioner may assist the owner of the failed system in seeking redress from the system's builder or other private party.

G. Every request for payment from the Fund shall be forever barred unless the owner has filed a complete application as required by the Department. The request shall be filed with the Commissioner within one year from the date that the onsite sewage system or components thereof first failed. However, if the owner was under a disability at the time the cause of action accrued, the tolling provisions of § 8.01-229 shall apply. The owner shall mail the request for payment from the Fund via the

United States Postal Service by certified mail, return receipt requested, addressed to the Commissioner.

In any action contesting the filing of the request for payment from the Fund, the burden of proof shall be on the owner to establish mailing and receipt of the notice in conformity with this section. The signed receipt indicating delivery to the Commissioner, when admitted into evidence, shall be prima facie evidence of filing of the request for payment from the Fund under this section. The request for payment from the Fund shall be deemed to be timely filed if it is sent by certified mail, return receipt requested, and if the official receipt shows that the mailing was within the prescribed time limits.

Notwithstanding any provision of this article, the liability for any payment from the Fund shall be conditioned upon the execution by the owner of a release approved by the Attorney General of all claims against the Commonwealth, its political subdivisions, agencies, and instrumentalities and against any officer or employee of the Commonwealth in connection with or arising out of the occurrence complained of.

H. The Commissioner and the Attorney General shall cooperatively develop an actuarially sound program and policy for identifying, evaluating, and processing requests for payment from the Fund.

I. If the Commissioner refuses the request for payment from the Fund, the owner may appeal the refusal to the State Health Department Sewage Handling and Disposal Appeal Review Board.

The Board may promulgate regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) for the administration of the Fund consistent with this chapter.

In the event the Fund is insufficient to meet requests for payment from the Fund, this section and the creation of the Fund shall not be construed to provide liability on the part of the Department or any of its personnel where no such liability existed prior to July 1, 1994.

1994, c. 747; 2007, cc. 448, 515; 2016, c. 90; 2021, Sp. Sess. I, c. 382.

§ 32.1-164.1:1. Validity of certain septic tank permits.

A. Any septic tank permit issued shall be valid for a period of 18 months from the date of issuance unless there has been a substantial, intervening change in the soil or site conditions where the septic system is to be located. However, if a building permit has been obtained or building construction has commenced, the permit may be extended for an additional 18 months. Applicants shall be informed of the septic tank permit validity period and advised to apply only when ready to begin construction.

B. Further, whenever any onsite sewage system is failing, or an owner has elected to voluntarily upgrade an onsite sewage system pursuant to § 32.1-164.1:3, and it is on or serves real property consisting of not less than one nor more than four dwelling units and the Board's regulations impose (i) a requirement for treatment beyond the level of treatment provided by the existing onsite sewage system when operating properly or (ii) a new requirement for pressure dosing, the owner may request a waiver from such requirements. The Commissioner shall grant any request for such waiver, unless he finds that the system was installed illegally without a permit. Any such waivers shall be recorded in the

land records of the clerk of the circuit court in the jurisdiction in which the property on which the relevant onsite sewage system is located. Except as provided in subsection C, waivers granted hereunder shall not be transferable and shall be null and void upon transfer or sale of the property on which the onsite sewage system is located. Additional treatment or pressure dosing requirements shall be imposed in such instances when the property is transferred or sold.

Any owner who (a) obtained a waiver to repair a failing onsite sewage system pursuant to this subsection on or between July 1, 2004, and December 6, 2011, (b) completed such repair, and (c) voluntarily upgrades the system may request, and shall receive, a voluntary upgrade waiver in accordance with this section and § 32.1-164.1:3. Any such waiver shall be recorded in the land records of the clerk of the circuit court in the jurisdiction where the onsite sewage system is located and shall supersede any prior waiver recorded pursuant to this section.

The owner of the relevant property shall disclose, in accordance with subsection D, that any operating permit for the onsite sewage system that has been granted a waiver authorized by this subsection shall be null and void at the time of transfer or sale of the property and that the Board's regulatory requirements for additional treatment or pressure dosing shall be required before an operating permit may be reinstated.

The provisions of this subsection shall apply only with respect to transfers by sale, exchange, installment land sales contract, or lease with option to buy residential real property consisting of not less than one nor more than four dwelling units, whether or not the transaction is with the assistance of a licensed real estate broker or salesperson.

C. The following are specifically allowed under the provisions of subsection B:

1. Transfers pursuant to court order including, but not limited to, transfers ordered by a court in administration of an estate, transfers pursuant to a writ of execution, transfers by foreclosure sale, transfers by a trustee in bankruptcy, transfers by eminent domain, and transfers resulting from a decree for specific performance.

2. Transfers to a beneficiary of a deed of trust by a trustor or successor in interest who is in default, transfers by a trustee under a deed of trust pursuant to a foreclosure, or transfers by a beneficiary under a deed of trust who has acquired the real property at a sale conducted pursuant to a foreclosure sale under a deed of trust or has acquired the real property by deed in lieu of foreclosure.

3. Transfers not for value by a fiduciary in the course of the administration of a decedent's estate, guardianship, conservatorship, or trust.

4. Transfers between spouses resulting from a decree of divorce or a property settlement stipulation pursuant to the provisions of Title 20.

5. Transfers to or from any governmental entity or public or quasi-public housing authority or agency.

6. Transfers pursuant to real estate purchase contracts where the owner has obtained a permit to voluntarily upgrade an onsite sewage system pursuant to § 32.1-164.1:3.

7. Other transfers consistent with criteria established by the Board of Health and the Real Estate Board.

D. The owner of residential real property subject to subsection B shall deliver to the purchaser a written disclosure prior to the acceptance of a real estate purchase contract. The written disclosure statement shall be in a separate document, developed by the Real Estate Board on or before January 1, 2006. Prior to that time, it shall be the obligation of the owner of such residential real property to prepare the written disclosure statement and provide it to the purchaser as otherwise provided herein.

E. If the disclosure required by subsection B is delivered to the purchaser after the acceptance of the real estate purchase contract, the purchaser's sole remedy shall be to terminate the real estate purchase contract at or prior to the earliest of the following: (i) three days after delivery of the disclosure in person; (ii) five days after the postmark if the disclosure is deposited in the United States mail, postage prepaid, and properly addressed to the purchaser; (iii) settlement upon purchase of the property; (iv) occupancy of the property by the purchaser; (v) the execution by the purchaser of a written waiver of the purchaser's right of termination under this chapter contained in a writing separate from the real estate purchase contract; or (vi) the purchaser making written application to a lender for a mortgage loan where such application contains a disclosure that the right of termination shall end upon the application for the mortgage loan.

In order to terminate a real estate purchase contract when permitted by this subsection, the purchaser shall, within the time required by this chapter, give written notice to the owner either by hand delivery or by United States mail, postage prepaid, and properly addressed to the owner. If the purchaser terminates a real estate purchase contract in compliance with this chapter, the termination shall be without penalty to the purchaser, and any deposit shall be promptly returned to the purchaser. Any rights of the purchaser to terminate the contract provided by this chapter shall end if not exercised prior to the earlier of (i) the making of a written application to a lender for a mortgage loan where the application contains a disclosure that the right of termination shall end upon the application for the mortgage loan or (ii) settlement or occupancy by the purchaser, in the event of a sale, or occupancy, or in the event of a lease with option to purchase.

F. A real estate licensee representing an owner of residential real property as the listing broker shall have a duty to inform each such owner represented by that licensee of the owner's rights and obligations under subsection B. A real estate licensee representing a purchaser of residential real property or, if the purchaser is not represented by a licensee, the real estate licensee representing an owner of residential real estate and dealing with the purchaser shall have a duty to inform each such purchaser of the purchaser's rights and obligations under subsection B. Provided a real estate licensee performs those duties, the licensee shall have no further duties to the parties to a residential real estate transaction under this section, and shall not be liable to any party to a residential real estate transaction for a violation of subsection B or for any failure to disclose any information regarding any real property subject to subsection B.

G. For the purposes of this section:

"Acceptance" means the full execution of a real estate purchase contract by all parties.

"Real estate purchase contract" means a contract for the sale, exchange, or lease with option to buy of real estate subject to this section.

H. The Real Estate Board shall enforce subsections D, E, and F pursuant to the provisions of Chapter 21 of Title 54.1 (§ 54.1-2100 et seq.).

1984, c. 401; 1986, c. 331; 1994, c. 747; 2004, c. 916; 2005, c. 469; 2011, c. 394; 2015, c. 111.

§ 32.1-164.1:2. Eligibility for betterment loans to repair or replace failing onsite sewage systems.

A. The Board shall establish a betterment loan eligibility program to assist owners with the repair, replacement, or upgrade of failing or noncompliant onsite sewage systems, and the Board may identify sources for betterment loans to be provided by private lenders, directly or through conduit lenders. In addition, owners may also apply to the Department for betterment loan eligibility to upgrade an onsite or alternative discharging sewage system that is not failing, provided such upgrade is for the purposes of reducing threats to public health, and ground and surface waters, including the reduction of nitrogen discharges.

B. Upon determination by the Department that the owner has one or more onsite sewage systems that are out of compliance with those regulations promulgated pursuant to this chapter, or in need of repair or replacement, the owner shall follow the requirements in the Board's regulations to initiate the repair or replacement of such systems. If the owner desires to be qualified by the Department to receive a betterment loan, at any time before the repair or replacement is completed, he shall provide the Department with an estimate of the approximate cost of such remedial work, which the Department shall accept. The issuance of a permit by the Department to repair or replace an onsite sewage system, combined with an estimate provided by the owner to the Department, shall demonstrate eligibility for a betterment loan. Upon a determination of eligibility, the Department shall notify the owner in writing. If the Department refuses the request for an eligibility letter, the owner may appeal the refusal to the State Health Department Sewage Handling and Disposal Appeal Review Board. It shall be the sole responsibility of the owner to secure the betterment loan from or through a private lender. Local health departments may provide a list of lenders available for this purpose. Nothing in this section shall be construed as allowing construction or modification of an onsite or alternative discharging sewage system without a permit issued by the Department.

C. Betterment loans made pursuant to this section shall be recorded in the deed book of the circuit court clerk's office for the locality in which the land is located and an abstract of the loan and betterment loan eligibility letter issued by the Department shall be indexed in the name of the owner. Betterment loans made pursuant to this section may be recorded in increments by the private lender as the repair or replacement of the onsite sewage system is completed, provided that in no event shall the total amount recorded exceed the estimate provided to the Department, without the Department approving an amendment to the repair permit, and issuing a revised betterment loan eligibility letter. The Department may, subject to appropriate waivers for economic hardship, charge the owner a fee

not to exceed $50 for each betterment loan eligibility letter request made by an owner. The Department may require that the owner or private lender provide the Department with proof that any betterment loan has been recorded in the deed book of the circuit court clerk's office for the locality in which the land is located.

The incurrence of a betterment loan pursuant to this section shall not be considered a breach of limitation or prohibition contained in a note, mortgage or contract on the transfer of an interest in the owner's property.

D. Where agreeable to the private lender and the conduit lender, if any, a locality may act as the collection agent for the payments made by the owner on a betterment loan. Any such payments collected by the locality shall be deemed to be held in trust by the locality for benefit of the private lender and conduit issuer, if any. The locality may receive a fee payable by the private lender or conduit loan provider, if any, for such service not to exceed one-eighth of one percent of the payments collected.

2009, c. 829.

§ 32.1-164.1:3. Permits for voluntary system upgrades.

Any owner desiring to voluntarily upgrade an onsite or alternative discharging sewage system that is not failing shall file an application, according to instructions from the Board, to obtain a construction permit to improve the system in accordance with the laws and regulations of the Board for repairing failing systems, provided such upgrade is for the purposes of reducing threats to the public health, or to ground and surface waters, including the reduction of nitrogen discharges.

The Department shall attach a statement to any permit issued pursuant to this section clearly stating that the upgrades specified in the permit are voluntary and not required by law. The Department may require the owner to indemnify and hold harmless the Department prior to the issuance of any such permit. Any permits issued pursuant to this section shall be subject to the provisions of § 32.1-164.1:1.

2011, c. 394.

§§ 32.1-164.2 through 32.1-164.7. Repealed.

Repealed by Acts 2007, cc. 881 and 929, cl. 8, effective January 1, 2008.

§ 32.1-164.8. Onsite Operation and Maintenance Fund established.

There is hereby created in the state treasury a special nonreverting fund to be known as the Onsite Operation and Maintenance Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller. All fees collected pursuant to subsection H of § 32.1-164 shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of supporting the operation and maintenance of onsite systems, including but not limited to (i) training operators and (ii) supporting the reporting system required by subsection H of § 32.1-164. Expenditures and disbursements from the

Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by Commissioner.

2007, c. 892.

§ 32.1-164.9. Regulations for chamber and bundled expanded polystyrene effluent distribution systems for onsite sewage systems.

The Board of Health shall promulgate regulations for chamber and bundled expanded polystyrene effluent distribution systems for onsite sewage systems permitted by the Commissioner pursuant to Article 1 (§ 32.1-164 et seq.) of Chapter 6 of Title 32.1. Such regulations shall include requirements for chamber and bundled expanded polystyrene effluent distribution systems for onsite sewage systems, which shall include (i) specifications for the physical construction of chamber and bundled expanded polystyrene effluent distribution systems including minimum exterior width, height, effluent storage capacity, and structural capacity; (ii) requirements for a permeable interface between chamber and bundled expanded polystyrene effluent distribution systems and trench sidewall soil surfaces for the absorption of wastewater; (iii) criteria for the allowable slope, maximum length, minimum sidewall depth, and minimum lateral separation of chamber and bundled expanded polystyrene effluent distribution system absorption trenches; (iv) criteria for substituting chamber and bundled expanded polystyrene effluent distribution systems for gravity percolation trenches and gravel and crushed stone low pressure systems; (v) criteria for determining the minimum area requirements for chamber and bundled expanded polystyrene effluent distribution system absorption trenches; and (vi) such other requirements pertaining to the promulgation of chamber and bundled expanded polystyrene effluent distribution system regulations for onsite sewage systems as may be deemed necessary by the Board.

2013, c. 202.

§ 32.1-165. Prior approval required before issuance of building permit; approved sewage system or nonconforming system.

A. No county, city, town, or employee thereof shall issue a permit for a building designed for human occupancy without the prior written authorization of the Commissioner or his agent. The Commissioner or his agent shall authorize the issuance of such permit upon finding that safe, adequate, and proper sewage treatment is or will be made available to such building, or upon finding that the issuance of such permit has been approved by the Review Board. "Safe, adequate, and proper" means a treatment works that complies with applicable regulations of the Board of Health that are in effect at the time of application.

B. The Commissioner shall develop an application and procedure for evaluating an installed treatment works and to determine whether to authorize issuance of a permit for a building designed for human occupancy.

C. Nothing in this section shall be construed to prevent the Commissioner or his agent from approving the use of a nonconforming treatment works, provided the treatment works was installed in

accordance with the Board of Health's applicable regulations in effect at the time of its installation, is not failing, and is designed and constructed for the sewage flow and strength expected from the building.

D. Nothing in this section shall be construed to prevent an owner of real property from receiving a voluntary upgrade pursuant to § 32.1-164.1:3, or other permit, as a condition of approval as a nonconforming treatment works.

E. The Board, Commissioner, and Department may accept a certified evaluation from (i) a professional engineer licensed pursuant to Chapter 4 of Title 54.1; (ii) an onsite soil evaluator, onsite sewage system operator, or onsite sewage system installer licensed pursuant to Chapter 23 of Title 54.1; (iii) or other individual with an appropriate certification from the National Sanitation Foundation, or equivalent. The Department may perform an inspection of the certified evaluation but shall not be required to perform a field check prior to the issuance of the written authorization in subsection A.

Code 1950, § 32-9; 1954, c. 646; 1964, c. 436; 1970, c. 645; 1972, c. 775; 1979, c. 711; 1984, c. 457; 2016, c. 96.

§ 32.1-166. Agreements with federal agencies.

The Board may enter into an agreement with any appropriate federal agency to regulate and monitor the collection, transportation, conveyance, treatment and disposal of sewage from common carriers or at federal facilities pursuant to the Public Health Service Act, United States Public Law 78-410, and any other applicable federal law.

Code 1950, § 32-9; 1954, c. 646; 1964, c. 436; 1970, c. 645; 1972, c. 775; 1979, c. 711.

Article 1.1 - STATE HEALTH DEPARTMENT SEWAGE HANDLING AND DISPOSAL APPEAL REVIEW BOARD

§ 32.1-166.1. Review Board; members.

There is hereby established, in the Department of Health, the State Health Department Sewage Handling and Disposal Appeal Review Board, consisting of seven members, appointed by the Governor subject to confirmation by the General Assembly. The members shall include one member who is a soil scientist; one member who is a professional engineer in private practice; one member who is a residential builder; one member who is an academic professional engaged in research and teaching in a soils-related discipline; one member who has had experience in the field of enforcement of onsite sewage disposal regulations; one member who is engaged in private soils analysis work related to the installation of onsite sewage systems; and one member from the public at large who may have experience in the installation of onsite sewage systems. The members shall serve at the pleasure of the Governor.

1984, c. 457; 1987, c. 47.

§ 32.1-166.2. Officers; secretary.

The Review Board, under rules adopted by itself, shall elect one of its members as chairman, for a term of two years, and may elect one of its members as vice-chairman. The Review Board may also elect a secretary, who may be a nonmember.

1984, c. 457.

§ 32.1-166.3. Oath.

Before entering upon the discharge of their duties, all members of the Review Board shall take an oath that they will faithfully and honestly execute the duties of their office during their continuance therein.

1984, c. 457.

§ 32.1-166.4. Meetings.

The Review Board shall meet eight times per year to hear appeals of denials of applications for onsite sewage disposal systems.

Any appeal shall be filed thirty days prior to a meeting in order to be placed on the docket. The Review Board shall provide its decision in writing within fifteen days of the date of the hearing to the person making the appeal, his representative and the Department of Health.

1984, c. 457; 1986, c. 331.

§ 32.1-166.5. Offices.

The Review Board shall be furnished adequate space and quarters in the suite of offices of the Department, where the Board's main office shall be located.

1984, c. 457.

§ 32.1-166.6. Review Board to hear appeals.

The Review Board shall hear all administrative appeals of denials of onsite sewage disposal system permits and appeals of refusals of indemnification requests filed pursuant to § 32.1-164.1:01, and refusals of betterment loan eligibility letters pursuant to § 32.1-164.1:2, and render its decision on any such appeal, which decision shall be the final administrative decision. Proceedings of the Review Board and appeals of its decisions shall be governed by the provisions of Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2.

In addition to the authority to render a final administrative decision, the Review Board, in its discretion, may develop recommendations for alternative solutions to the conditions resulting in denial of the permit or refusal to indemnify and remand the case to the Department of Health for reconsideration.

For purposes of this section "betterment loan" is as defined in § 32.1-163.

1984, c. 457; 1986, c. 331; 1994, c. 747; 2009, c. 829.

§ 32.1-166.7. Subpoenas; witnesses; designation of subordinates.

In any matter before it on appeal for hearing and determination, the Review Board or its designated subordinates may compel the attendance of all needed witnesses in like manner as a circuit court,

save the Review Board shall not have the power of imprisonment. In taking evidence, the chairman or any member of the Review Board, or its designated subordinates, shall have the power to administer oaths to witnesses. Where a designated subordinate of the Review Board presides over hearings on appeals, such subordinate shall submit recommended findings and a decision to the Review Board pursuant to § 2.2-4020.

1984, c. 457.

§ 32.1-166.8. Record of decisions.

A record of all decisions of the Review Board, properly indexed, shall be kept in the office of such Review Board. The records shall be open to public inspection at all times during business hours.

1984, c. 457.

§ 32.1-166.9. Interpretation of application of regulations; recommendation of modifications.

The Review Board shall interpret the application of the provisions of the Sewage Handling and Disposal Regulations in its review of appeals and shall make such recommendations, as it deems appropriate, to the Board for modification, amendment or repeal of any such provisions of the regulations. A record of all such recommendations, and of the Board's actions thereon, shall be kept in the office of the Review Board. Such record shall be open to public inspection at all times during business hours.

1984, c. 457.

§ 32.1-166.10. Appeals fees.

The Department shall establish a reasonable fee to be charged to the appealing party commensurate with the time and expenses related to the handling of each appeal.

1984, c. 457; 1994, c. 747.

Article 2 - PUBLIC WATER SUPPLIES

§ 32.1-167. Definitions.

As used in this article, unless the context clearly requires a different meaning:

"Aesthetic standards" means water quality standards which involve those physical, biological, and chemical properties of water that adversely affect the palatability and consumer acceptability of water through taste, odor, appearance, or chemical reaction.

"Chronically noncompliant waterworks" means a waterworks that is unable to provide pure water for any of the following reasons: (i) the waterworks' record of performance demonstrates that it can no longer be depended upon to furnish pure water to the persons served; (ii) the owner has inadequate technical, financial, or managerial capacity to furnish pure water to the persons served; (iii) the owner has failed to comply with an order issued by the Board or Commissioner pursuant to § 32.1-26 or 32.1-175.01; (iv) the owner has abandoned the waterworks and has discontinued supplying pure water to the persons served; or (v) the owner is subject to a forfeiture order pursuant to § 32.1-174.1.

"Governmental entity" means the Commonwealth, a town, city, county, service authority, sanitary district, or any other governmental body established under state law, including departments, divisions, boards, or commissions.

"Human consumption" means drinking, food preparation, dishwashing, bathing, showering, hand washing, teeth brushing, and maintaining oral hygiene.

"Owner" means an individual, group of individuals, partnership, firm, association, institution, corporation, governmental entity, or the federal government, that supplies or proposes to supply water to any person within this Commonwealth from or by means of any waterworks.

"Pure water" means water fit for human consumption that is (i) sanitary and normally free of minerals, organic substances, and toxic agents in excess of reasonable amounts and (ii) adequate in quantity and quality for the minimum health requirements of the persons served.

"Special order" means an administrative order issued to any person to comply with: (i) the provisions of any law administered by the Board, (ii) any condition of a permit, (iii) any regulation of the Board, or (iv) any case decision, as defined in § 2.2-4001, of the Board. A special order may include a civil penalty of not more than $1000 for each day of violation.

"Water supply" means water taken into a waterworks from wells, streams, springs, lakes, and other bodies of surface water, natural or impounded, and the tributaries thereto, and all impounded ground water but does not include any water above the point of intake of such waterworks.

"Waterworks" means a system that serves piped water for human consumption to at least 15 service connections or 25 or more individuals for at least 60 days out of the year. "Waterworks" includes all structures, equipment, and appurtenances used in the storage, collection, purification, treatment, and distribution of pure water except the piping and fixtures inside the building where such water is delivered.

Code 1950, § 62.1-45; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1997, c. 342; 2007, cc. 648, 774; 2014, c. 333.

§ 32.1-168. Exemptions.

The provisions of this article shall not be applicable to a waterworks which meets all of the following conditions:

1. The waterworks consists only of distribution and storage facilities and does not have any collection or treatment facilities;

2. The waterworks obtains all of its water from, but is not owned or operated by, a waterworks to which this article is applicable;

3. The waterworks does not sell water to any person; and

4. The waterworks is not a carrier which conveys passengers in interstate commerce.

1979, c. 711.

§ 32.1-169. Supervision by Board.

A. The Board shall have general supervision and control over all water supplies and waterworks in the Commonwealth insofar as the bacteriological, chemical, radiological, and physical quality of waters furnished for human consumption may affect the public health and welfare and may require that all water supplies be pure water. In exercising such supervision and control, the Board shall recognize the relationship between an owner's financial, technical, managerial, and operational capabilities and his capacity to comply with state and federal drinking water standards.

B. The Board shall adopt regulations establishing maximum contaminant levels (MCLs) in all water supplies and waterworks in the Commonwealth for (i) perfluorooctanoic acid and perfluorooctane sulfonate, and for such other perfluoroalkyl and polyfluoroalkyl substances as the Board deems necessary; (ii) chromium-6; and (iii) 1,4-dioxane. Each MCL shall be protective of public health, including of vulnerable subpopulations, including pregnant and nursing mothers, infants, children, and the elderly, and shall not exceed any MCL or health advisory for the same contaminant adopted by the U.S. Environmental Protection Agency. In establishing such MCLs, the Board shall review the recommendations of any work group convened by the Commissioner after July 1, 2022, to study the occurrence of such contaminants in public drinking water, MCLs adopted by other states, studies and scientific evidence reviewed by such states, material in the Agency for Toxic Substances and Disease Registry of the U.S. Department of Health, and current peer-reviewed scientific studies produced independently or by government agencies.

Code 1950, § 62.1-46; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1994, c. 395; 2014, c. 333; 2020, c. 1097; 2022, c. 585.

§ 32.1-170. Regulations.

A. The regulations of the Board governing waterworks, water supplies, and pure water shall be designed to protect the public health and promote the public welfare and shall include criteria and procedures to accomplish these purposes.

The regulations may include, without limitation:

1. Requirements and procedures for the issuance of permits required by this article;

2. Minimum health and aesthetic standards for pure water;

3. Minimum standards for the quality of water which may be taken into a waterworks;

4. Criteria for the siting, design, and construction of water supplies and waterworks;

5. Requirements for inspections, examinations, and testing of raw or finished water;

6. A requirement that owners submit (i) regular samples of water for bacteriological, chemical, radiological, physical, or other tests or (ii) the results of such tests from such laboratory as may be acceptable to the Commissioner;

7. Requirements for record keeping and reporting;

8. Methodology for determining the waterworks operation fee authorized by § 32.1-171.1;

9. Requirements and criteria for the development and maintenance of an emergency management plan for each community public water supply for the provision of pure water during any extended power outage; and

10. Such other provisions as may be necessary to guarantee a supply of pure water.

B. The regulations of the Board governing waterworks, water supplies, and pure water shall include a procedure whereby waterworks serving fewer than 10,000 people may seek and the Board may grant a waiver of any requirement that the waterworks mail copies of its consumer confidence report to each customer of the waterworks at least once annually. In such cases, the waterworks owner shall publish, by July 1 of each year, in a newspaper of general circulation serving the area served by the waterworks, and by such other means as the Board may deem appropriate, (i) a copy of the consumer confidence report, (ii) notice that copies of the consumer confidence report will not be mailed to customers of the waterworks, and (iii) notice that copies of the consumer confidence report shall be made available to the public upon request. The waterworks owner shall certify compliance with the requirements of this subsection to the Board no later than October 1 of each year.

Code 1950, §§ 62.1-47, 62.1-48, 62.1-51; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1992, c. 804; 2004, c. 317; 2011, cc. 804, 843.

§ 32.1-171. Technical assistance as to sources and purity.

The Commissioner shall, upon request and without charge, provide technical assistance to owners regarding the most appropriate source of water supply and the best method of assuring pure water, but the Commissioner shall not prepare plans, specifications or detailed estimates for such owners. The technical assistance provided by this section shall be exclusive of the Waterworks Technical Assistance Program required by § 32.1-171.1.

Code 1950, § 62.1-49; 1964, c. 475; 1968, c. 659; 1979, c. 711; 1992, c. 804.

§ 32.1-171.1. Waterworks operation fee required; special fund established; certain technical assistance program to be provided.

A. Every owner of a waterworks shall pay to the Department a waterworks operation fee of no more than $160,000 per year. Based upon the number of persons served, the number of connections, or the classification of the waterworks, the Board shall, pursuant to its regulations, establish the fee to be charged each such owner and may exempt sizes and classes from the required fee. Any fee in excess of $10,000 shall be payable quarterly. The Board shall adjust the fee schedule so that the revenues from such fees cover the costs necessary to operate the Waterworks Technical Assistance Program required by this section.

B. In order to assist waterworks owners in complying with the requirements of the Safe Drinking Water Act (42 U.S.C. § 300f et seq.) and associated state regulations, there is hereby established in the state treasury a special fund to be known as the Waterworks Technical Assistance Fund, hereinafter referred to as the Fund. The fees required by this section shall be transmitted to the Comptroller to be deposited into the Fund. The income and principal of the Fund shall be used only and exclusively for

the technical assistance required by this section. The State Treasurer shall be custodian of the moneys deposited in the Fund. No part of the Fund, either principal or interest earned thereon, shall revert to the general fund of the state treasury.

C. Moneys in the Fund shall be used by the Department to conduct the Waterworks Technical Assistance Program, which shall include, but need not be limited to: (i) training for operator certification, (ii) engineering evaluation and advice, (iii) sample collection for laboratory analysis, and (iv) educational seminars.

1992, c. 804.

§ 32.1-171.2. Water Supply Assistance Grant Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Water Supply Assistance Grant Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller. All funds appropriated as matching funds for moneys available through the federal Safe Drinking Water Act, all penalties and charges directed to this fund by §§ 32.1-27, 32.1-175.01 and 32.1-176, and all other funds from any public or private source directed to the Fund shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes found in subsection B. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner at the direction of the Board.

B. The Board shall utilize the moneys appropriated as matching funds for that purpose and, subject to other available funds, may make Water Supply Assistance Grants from the Fund to localities and the owners of waterworks to assist in the provision of drinking water. The Board shall develop guidelines establishing the (i) criteria for grant eligibility, (ii) conditions to be included in grants, and (iii) grant distribution priorities. Among the factors that shall be included in the criteria for grant eligibility and in the grant distribution priorities shall be the financial condition of the locality wherein a grant is sought.

C. The Administrative Process Act (§ 2.2-4000 et seq.) shall not apply to the development of guidelines for the Fund. However, the process for development of the guidelines by the Board shall include (i) the use of an advisory committee composed of interested parties, (ii) a minimum sixty-day public comment period on draft guidelines followed by a public hearing, (iii) written responses to all comments received, and (iv) notice of the availability of draft guidelines and final guidelines to all who request such notice.

1999, c. 786.

§ 32.1-172. Permit required.

A. No owner shall establish, construct or operate any waterworks or water supply in the Commonwealth without a written permit from the Commissioner, except for the extension of water dis-

tribution piping having a diameter of eight inches or less and serving less than fifteen equivalent residential connections.

B. The application for such a permit shall comply with regulations of the Board and shall be accompanied by a certified copy of the maps, plans and specifications for the construction of such waterworks, a description of the source or sources from which it is proposed to derive the water supply and the manner of storage, purification or treatment proposed for the water supply prior to its delivery to consumers.

The application also shall include a comprehensive business plan detailing the technical, managerial, and financial commitments to be made by the owner in order to assure that system performance requirements for providing the water supply will be met over the long term. The Board, in consultation with the State Corporation Commission, shall establish the criteria to be used by the applicant in the development of a business plan.

In addition, the Board may require the submission of a business plan by those existing waterworks that have demonstrated significant noncompliance with the waterworks regulations. The Board may waive the requirement for submission of a comprehensive business plan for applicants who have demonstrated a history of acceptable compliance with waterworks regulations.

If any applicant so requests, the Board shall not disclose the contents of the comprehensive business plan except as necessary to perform its duties.

C. The permit may state the permitted capacity of the waterworks, the permitted source or sources of the water supply, the permitted manner of storage, purification and treatment for the water supply and such other conditions as the Commissioner may deem necessary to afford a supply of pure water.

D. Except as may be provided by regulation of the Board, no other source of water supply shall subsequently be used for any such waterworks, nor shall any change in the manner of storage, purification and treatment of the water supply be made without obtaining an additional or amended permit.

E. Whenever application shall be made to the Commissioner for a permit, he shall examine the application and, as soon as practicable thereafter, shall issue the permit if, in his judgment, the proposed waterworks will furnish pure water. If the proposed waterworks is not in compliance with all regulations of the Board but, in the opinion of the Commissioner, the public health will not be jeopardized, the Commissioner may issue a temporary permit for such period of time and subject to such conditions as the Commissioner may deem appropriate for the owner to achieve compliance with such regulations.

F. No permit shall be assigned or transferred.

Code 1950, §§ 62.1-50, 62.1-56; 1964, c. 475; 1968, c. 659; 1979, c. 711; 1994, cc. 395, 708.

§ 32.1-173. Additional or amended permits.

A. Any owner intending to make changes, alterations or improvements to a waterworks for which a permit has been granted shall apply to the Commissioner for an additional or amended permit in a

manner prescribed by regulations of the Board. The Commissioner shall review and act upon the application in the manner set forth in § 32.1-172.

B. The Commissioner may, on his own motion, amend any permit whenever he determines that:

1. The existing permit is no longer valid;

2. Changes, alterations, or improvements to the waterworks are necessary to provide an adequate supply of pure water; or

3. A change has occurred in the manner of storage or treatment or the source of the water supply.

Code 1950, § 62.1-55; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711.

§ 32.1-173.1. Increase in charges to finance required changes.

Any owner required to make any change, alteration or improvement in its waterworks or water supply may increase its charges for water to finance or defray the cost of such change, alteration or improvement and any extra costs incident to the maintenance and operation thereof.

Code 1950, § 62.1-53; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711.

§ 32.1-174. Revocation of permits.

The Commissioner may revoke any permit issued pursuant to this article whenever he determines that:

1. The waterworks can no longer be depended upon to furnish pure water;

2. The capacity of the waterworks is inadequate for the purpose of furnishing pure water;

3. The owner has failed to abide by an order issued by the Commissioner;

4. The owner has abandoned the waterworks and discontinued supplying pure water; or

5. The owner has failed to pay the waterworks operation fee required by § 32.1-171.1.

Code 1950, §§ 62.1-53, 62.1-55; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1992, c. 804.

§ 32.1-174.1. Bonds of permit holders.

A. The Board may by regulation require owners holding or issued permits for waterworks pursuant to this article, to post bonds or deposit funds to be placed in escrow.

B. The Board or the governing body of a county, city or town in which a waterworks is located may request the circuit court having jurisdiction where the waterworks is located to order forfeiture of the owner's bond or escrow account upon revocation of the Waterworks Operation Permit by the Board or Commissioner pursuant to § 32.1-174.

If the foregoing condition is met, the court shall order forfeiture of such bond or escrow account, in whole or in part, unless the court finds the forfeiture would result in manifest injustice.

C. In addition to ordering such forfeiture, the court may, with the concurrence of the governing body of the county, city or town in which the waterworks is located, place the waterworks in receivership

naming the county, city, or town, or any public service authority created by the county, city or town, as receiver.

D. Any sums forfeited pursuant to subsection B shall be paid in the amount of such forfeiture to the county, city or town in which the waterworks is located (i) if the county, city, or town, or a public service authority created by the county, city or town, initiates eminent domain proceedings for the condemnation of the waterworks within one year of the date of the order of forfeiture or (ii) if the county, city, town or public service authority operates the waterworks pursuant to a decree of an appropriate circuit court vesting receivership of the waterworks in the county, city, town or public service authority. If the governing body of the county, city, or town, or a public service authority created by the county, city or town, fails to initiate such condemnation proceedings within one year of the date of forfeiture of any bond or to accept receivership of the waterworks from the circuit court, the funds forfeited shall be paid to the general fund of the Commonwealth.

E. The Board may adopt regulations for determining the amount of the bond or funds to be placed in escrow based upon the number of persons served, the number of connections served, the age and condition of the waterworks system infrastructure, the cost of maintaining, repairing, or replacing the waterworks system infrastructure, and the water supply capacity of the permit holder.

F. No state, local or other governmental agency shall be required to post a bond or deposit funds. The Board may, by regulation, exempt classes of permit holders from such requirements if the Board determines such classes present no significant risks to public health and safety.

G. An acceptable bond for the purposes of this section shall be a bond issued by a fidelity or surety company authorized to do business in Virginia, a personal bond secured by such collateral as the Board may require or a cash bond.

1980, c. 402; 2011, c. 502.

§ 32.1-174.2. Duties of electric utilities.

No electric utility shall disconnect electrical service to any waterworks holding a permit issued pursuant to this article until the utility has (i) provided sixty days' written notice to the Board of its intent to disconnect electrical service to the waterworks; (ii) filed with the Board at least sixty days prior to the disconnection a written request that the Board initiate forfeiture proceedings against any bond posted or funds deposited by the permit holder; and (iii) provided sixty days' written notice to the governing body of the county, city or town in which the waterworks is located.

1980, c. 402.

§ 32.1-174.3. Appointment of receiver for certain private waterworks; grounds for such appointment; petition and hearing, etc.

A. In addition to the remedies provided in § 32.1-27 and this chapter for civil and criminal penalties and injunctive or other relief, the Commissioner may petition the circuit court for the jurisdiction in which any private waterworks is located for the appointment of a receiver for such waterworks in accordance with the provisions of this section. Such petition may be filed at any time that the

Commissioner finds that the waterworks is unable or unwilling to provide adequate and safe service for any of the following reasons:

1. The waterworks can no longer be depended upon to furnish pure water;

2. The waterworks has inadequate capacity to furnish pure water to its customers;

3. The owner has failed to comply with an order issued by the Commissioner;

4. The owner has abandoned the waterworks and has discontinued supplying pure water to his customers;

5. The owner is subject to a forfeiture order pursuant to § 32.1-174.1; or

6. The Commissioner has issued an emergency order because there is an imminent danger to the public health and welfare resulting from the operation of the waterworks or the source of the water supply.

B. Upon the filing of a petition for appointment of a receiver for a private waterworks, the court shall hold a hearing within 10 days, at which time the Commissioner and the owner of the waterworks may present evidence. The court may grant the petition if it finds any one or more of the conditions identified in subsection A and the court further finds that the conditions will not be remedied and that the health and welfare of the owner's customers will not be protected unless the petition is granted.

C. Upon appointment the receiver shall take possession of the assets of the waterworks and shall operate the waterworks in the best interests of the customers. The receiver shall have such powers and duties to operate and manage the waterworks as the court may grant and direct, including the filing of such reports as the court may direct and the power to receive, conserve, protect, and disburse funds; further, the provisions of Article 1 (§ 8.01-582 et seq.) of Chapter 22 of Title 8.01 shall apply, mutatis mutandis.

The court may grant injunctive relief as it deems appropriate to the Commissioner or the receiver either in conjunction with or subsequent to the granting of a petition for appointment of a receiver under this section.

D. Control of and responsibility for the waterworks shall remain in the receivership until the waterworks can, in the best interest of the customers, be returned to the owner, transferred to a new owner, or otherwise configured as the court may determine to be in the best interests of the public and the customers.

E. The court may terminate the receivership on the motion of the Commissioner, the receiver, or the owner, upon finding, after a hearing, that the conditions initiating the petition for the appointment of a receiver have been eliminated or resolved. Within 30 days after such termination, the receiver shall file a complete report of his activities with the court, including an accounting for all property of which he took possession and all funds collected.

A receiver appointed pursuant to this section shall be an officer of the court, shall not be liable for the conditions of the waterworks that existed prior to his receivership, and shall not be personally liable,

except for his own gross negligence or intentional acts, to injuries or damage to property relating to the waterworks during his receivership.

This subsection shall not, however, be construed to relieve any owner of any duty imposed by law or of any civil or criminal liability incurred by reasons of any act or omission of such owner.

2003, c. 458.

§ 32.1-174.4. Identification and elimination of chronically noncompliant waterworks.

A. The Board shall promulgate regulations for the implementation of a program to (i) identify chronically noncompliant waterworks as defined in § 32.1-167 and (ii) create mechanisms or enforcement options for eliminating chronically noncompliant waterworks.

B. Out of such funds as may be appropriated, the Commissioner of Health, with the assistance of the Office of the Attorney General, is authorized to enter into contracts for (i) the design of a program for the identification of noncompliant waterworks and (ii) the development of enforcement options to carry out the provisions of this act.

2007, cc. 648, 774.

§ 32.1-175. Emergency orders; appeal.

A. The Commissioner may issue emergency orders in any case where there is an imminent danger to the public health and welfare resulting from the operation of any waterworks or the source of a water supply. The Commissioner may order the immediate cessation of the operation of any waterworks or the use of any water supply or the correction of any condition causing the production or distribution of any water constituting an imminent danger to the public health and welfare. Emergency orders shall be effective for a period determined by the Commissioner.

B. An emergency order issued by the Commissioner may be appealed in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

Code 1950, § 62.1-62; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1986, c. 615.

§ 32.1-175.01. Issuance of special orders.

Notwithstanding any other provision of law and to the extent consistent with federal requirements, following a proceeding as provided in § 2.2-4019, the Board may issue a special order that may include a civil penalty against an owner who violates this article or any order or regulation adopted thereto by the Board. The issuance of a special order shall be considered a case decision as defined in § 2.2-4001. Civil penalties collected pursuant to this section shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2.

1997, c. 342, § 32.1-176.1:1; 1999, c. 786.

§ 32.1-175.1. Notice to local government.

A. Upon issuing a notice of violation of any provision of regulation promulgated pursuant to this article to the owner of a waterworks or water supply, the Commissioner shall simultaneously notify the chief

administrative officer or his designee of the county, city or town in which such waterworks or water supply is located.

B. Spotsylvania County is authorized to enact an ordinance requiring the owner of any waterworks or water supply located in the county to provide the chief administrative officer of the county with the results of all tests performed on such waterworks or water supply.

1987, c. 400.

§ 32.1-176. Penalty.

In addition to the provisions of § 32.1-27, any owner who violates any provisions of this article or any order or regulation adopted pursuant thereto shall, upon such finding by a court of competent jurisdiction, be assessed a civil penalty of not more than $5,000 for each day of such violation. All penalties under this section shall be recovered in a civil action brought by the Attorney General in the name of the Commonwealth. Civil penalties collected pursuant to this section shall be paid into the state treasury and credited to the Water Supply Assistance Grant Fund created pursuant to § 32.1-171.2.

Code 1950, § 62.1-59; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1999, c. 786.

Article 2.1 - PRIVATE WELL CONSTRUCTION

§ 32.1-176.1. Short title.

This article shall be known and may be cited as the "Virginia Private Well Construction Act."

1986, c. 401.

§ 32.1-176.2. Findings and policy.

The General Assembly finds that the improper construction of private wells can adversely affect aquifers as ground water resources in the Commonwealth. Consistent with the duty to protect these ground water resources and to safeguard the public welfare, safety and health it is declared to be the policy of this Commonwealth to require that the construction and location of private wells conform to reasonable requirements.

1986, c. 401.

§ 32.1-176.3. Definitions.

As used in this article:

"Construction of wells" means acts necessary to construct wells, including the location of wells.

"Plat" or "survey plat" means the schematic representation of a parcel of land, showing the property boundaries, the proposed site of the water well, and any potential sources of contamination, prepared by an individual licensed by the Commonwealth to perform such services.

"Private well" means any water well constructed for a person on land which is owned or leased by that person and is usually intended for household, ground water source heat pump, agricultural use, industrial use or other nonpublic water well.

"Site plan" means a sketch of a parcel of land, showing the property boundaries, the proposed site of the water well, and any potential sources of contamination.

1986, c. 401; 2009, c. 59.

§ 32.1-176.4. Powers and duties of Board and Department; regulations; fees.

A. The Board shall adopt regulations pertaining to the location and construction of private wells in the Commonwealth. These regulations shall include minimum storage capacity and yield requirements for residential drinking wells. The certified water well systems provider shall certify the storage capacity and the yield of the well on a form provided by the Department at the time the well is completed. The Department shall enforce the provisions of this article and any rules and regulations adopted pursuant thereto. However, for private wells located in the Counties of Fairfax, Goochland, James City, Loudoun, Powhatan, and Prince William and the City of Suffolk, the governing body of such county or city may, by ordinance, establish standards which are consistent with Board standards pertaining to location and testing of water therefrom and more stringent than those adopted by the Board pertaining to construction and abandonment. However, any county or city granted these additional powers shall not require certification for drillers of monitoring wells and any recovery wells associated with such monitoring wells.

B. A fee of $40 shall be charged for filing an application for a private well construction permit with the Department. Funds received in payment of such charges shall be transmitted to the Comptroller for deposit. The funds from the fees shall be credited to a special fund to be appropriated by the General Assembly, as it deems necessary, to the Department for the purpose of carrying out the provisions of this title. The Board, in its regulations, shall establish a procedure for the waiver of fees for persons whose incomes are below the federal poverty guidelines established by the United States Department of Health and Human Services or when the application is for replacement of a well. If the Department denies the permit for land on which the applicant seeks to construct his principal place of residence, then such fee shall be refunded to the applicant.

From such funds as are appropriated to the Department from the special fund, the Board shall apportion a share to the local or district health departments to be allocated in the same ratios as provided for the operation of such health departments pursuant to § 32.1-31. Such funds shall be transmitted to the local or district health departments on a quarterly basis.

C. The Board's regulations shall provide for the issuance of an express geothermal permit allowing, upon proper registration and payment of application fees, the construction of wells used solely for a closed loop geothermal heating system. The express geothermal permit shall include:

1. A requirement that all well construction be performed by a person holding a valid, appropriate contractor license with water well classification pursuant to Chapter 11 (§ 54.1-1100 et seq.) of Title 54.1;

2. A requirement that the contractor provide a registration statement to the Department prior to beginning construction of the geothermal heating system certifying that the location and construction of the geothermal heating system will comply with the private well regulations;

3. A requirement that the registration statement accurately identify the property location, the owner's name, address, and contact information, and the contractor's name, address, and contact information;

4. A requirement that the registration statement include a detailed site plan, drawn to scale, showing the location of the geothermal heating system and any potential sources of contamination;

5. A provision that construction of the geothermal heating system may begin immediately upon submittal of a proper registration statement; and

6. A provision that a single application and a single fee be required for any geothermal well system. The fee will be equal to the fee for a single private well.

1986, c. 401; 1988, c. 203; 1991, c. 514; 1992, c. 599; 1993, cc. 85, 728, 794; 1994, cc. 141, 747; 1999, c. 633; 2004, c. 72; 2009, cc. 105, 710.

§ 32.1-176.5. Construction permit; local government authority to require analysis of water.

A. Any person intending to construct a private well shall apply to the Department for and receive a permit before proceeding with construction. The permit application shall include a site plan. No survey plat shall be required. In all cases, it shall be the landowner's responsibility to ensure that the water well is properly located on the landowner's property. This permit shall be issued no later than 60 days from application and in accordance with the Board's regulations. In addition, an inspection shall be made after construction to assure that the construction standards are met.

B. The local governing bodies of the Counties of Albemarle, Bedford, Chesterfield, Clarke, Culpeper, Fairfax, Fauquier, Goochland, James City, Loudoun, Orange, Powhatan, Prince William, Rappahannock, Stafford, Warren, and York, and the Cities of Chesapeake, Manassas, Manassas Park, Suffolk, and Virginia Beach may by ordinance establish reasonable testing requirements to determine compliance with existing federal or state drinking water quality standards and require that such testing be done prior to the issuance of building permits. Such testing requirements shall apply only to building permit applicants proposing to utilize private ground water wells as their primary potable water source. In developing such an ordinance, the local governing body shall consider (i) the appropriate ground water constituents to be tested using the above standards as guidance, (ii) the reasonable cost of such testing that may be borne by the applicant, and (iii) the availability of certified laboratories to perform such services. However, no such test shall be conducted by Consolidated Laboratories. The applicant shall be notified of the test results with respect to such established standards.

C. Any local governing body referenced in subsection B of this section that has adopted a well abandonment ordinance may require property owners to close and cap abandoned or inactive wells pursuant to that ordinance.

1986, c. 401; 1988, c. 441; 1989, cc. 454, 696; 1990, cc. 544, 547, 661; 1993, c. 794; 1995, c. 220; 1996, c. 202; 1999, c. 633; 2003, c. 500; 2009, c. 59; 2014, c. 599; 2022, cc. 225, 226.

§ 32.1-176.5:1. Department to test for oil contamination; maintain lists of private laboratories.

A. The Department shall disseminate the information on confirmed oil releases and discharges, contained in the Department of Environmental Quality's monthly report prepared pursuant to § 62.1-44.15:4.1, to local health departments and Department field offices. Local health departments and field offices shall make the reports available for public inspection.

B. Upon the request of any person whose private well is located in an area, as defined by the Department, where an oil release or discharge has been confirmed in the reports prepared by the Department of Environment Quality, the Department shall test the water supply of the private well for the presence of oil to determine whether there is risk to public health. The costs of such tests shall be borne by the person requesting the test, unless the Department finds the oil release or discharge poses a potential risk to the health of persons using that private well.

C. The Department shall maintain and make available, upon the request of any person, a list of various private companies located throughout the Commonwealth that possess the technical expertise to analyze water samples for the presence of oil constituents. Any private company providing such laboratory testing services may contact the Department and shall have its name placed on the list. The placement of a company on the list shall not constitute an endorsement of any company or its services.

1998, c. 795.

§ 32.1-176.5:2. Prohibition on private well construction.

A. No private well shall be constructed within 50 feet of the property line with an adjacent property of three acres or larger that is used for an agricultural operation, as defined in § 3.2-300. The following shall be exempt: (i) the owner of the adjacent property that is used for an agricultural operation may grant written permission for construction within 50 feet of the property line; or (ii) certification that no other site on the property complies with the Board's regulations for the construction of a private well.

B. The Department shall accept private site evaluations and designs, in compliance with the Board's regulations for the construction of private wells, designed and certified by a licensed professional engineer, in consultation with a licensed onsite soil evaluator, or by a licensed onsite soil evaluator. The evaluations and designs included within such submissions shall be certified as complying with the Board's regulations implementing this chapter. The Department shall not be required to perform a field check of private evaluations and designs prior to issuing the requested letter, permit, or approval. However, the Department may conduct such review of the work and field analysis as deemed necessary to protect the public health, integrity of the Commonwealth's environment, and the provisions of this chapter.

C. The Department, prior to issuing a permit, shall require any owner applying for a permit to construct a private well pursuant to the exemptions in subsection A to submit documentation that affirms the well construction site complies with the provisions of this section.

2007, c. 403; 2008, c. 62; 2016, c. 90.

§ 32.1-176.6. Inspection.

The Department shall have the authority to conduct such inspections as it may find reasonably necessary to ensure that the construction work conforms to applicable construction standards.

1986, c. 401.

§ 32.1-176.7. Other agencies to cooperate with Department.

The Department of Housing and Community Development and the State Water Control Board shall cooperate fully and promptly with the Department of Health in the administration of this article.

1986, c. 401.

Article 2.2 - Wells Near Certain Coal Ash Ponds

§ 32.1-176.8. Definitions.

For the purposes of this article:

"Coal ash pond" means any natural topographic depression, man-made excavation, or diked area that (i) is designed to hold an accumulation of coal combustion residuals and liquids; (ii) treats, stores, or disposes of coal combustion residuals; and (iii) is located in the Chesapeake Bay Watershed at the Bremo Power Station in Fluvanna County, Chesapeake Energy Center in the City of Chesapeake, Chesterfield Power Station in Chesterfield County, or Possum Point Power Station in Prince William County.

"DEQ" means the Department of Environmental Quality.

"Utility" means the owner or operator of a coal ash pond.

2020, c. 845.

§ 32.1-176.8:1. Private well and public water supply well testing near coal ash ponds; monitoring.

A. For each private well or public water supply well within 1.5 miles of any coal ash pond, the utility shall commission a well water test on or before July 1, 2021, on behalf of the owner of the well. The test shall be conducted by a company certified to perform such tests by the Virginia Environmental Laboratory Accreditation Program. The utility shall recommend a certified laboratory to perform the test, but the owner of the well may elect to have an independent certified laboratory perform the test. Such test shall, at a minimum, test for alkalinity (bicarbonate), alkalinity (carbonate), alkalinity (total), aluminum, antimony, arsenic, barium, beryllium, boron, cadmium, calcium, chloride, chromium (hexavalent), chromium (total), cobalt, copper, iron, lead, lithium, magnesium, manganese, mercury, molybdenum, nickel, potassium, radium (total alpha), radium-228, radium (radium-226 and radium-228 combined), selenium, sodium, strontium, sulfate, thallium, thorium, vanadium, zinc, and total dissolved solids. The utility shall pay the reasonable costs of such testing.

B. The utility shall commission a test as required by subsection A for each private well or public water supply well (i) once per year during each of the five years following the approval by DEQ of the closure of a coal ash pond and (ii) once every five years thereafter.

C. If any sampling, test, or water quality analysis conducted pursuant to the provisions of this section indicates that water from a private well or public water supply well exceeds any U.S. Environmental Protection Agency Maximum Contaminant Level for drinking water, the utility shall (i) within seven days of the receipt of test results, either replace the contaminated well with an alternate supply of potable drinking water or provide a treatment system for the contaminated well in order to render the water supply potable and (ii) within 90 days of the receipt of test results, either provide an alternate supply of water that is safe for other household uses or provide a treatment system for the contaminated well in order to render the water supply safe for other household uses. All costs associated with such provision of alternate supplies of water or treatment shall be borne by the utility. In lieu of providing an alternate supply of water or a treatment system pursuant to clause (i) or (ii) and to the extent service is available, the utility may elect to pay the costs of connecting the property owner to a water utility operated by a city or county.

D. The Department of Health and DEQ shall receive the results of the tests conducted pursuant to the provisions of this section.

E. Nothing in this section shall be construed to preclude or impair the right of any property owner to refuse the sampling or testing of any private well or public water supply well on his property. The requirements of this section are in addition to other applicable laws or regulations, and nothing in this section, including the requirement to commission testing or to treat or replace contaminated drinking water, shall preempt or preclude any additional legal action or remedy authorized by law.

2020, c. 845.

Article 3 - SOLID AND HAZARDOUS WASTE MANAGEMENT

§§ 32.1-177 through 32.1-186. Repealed.

Repealed by Acts 1986, c. 492.

Article 4 - MOSQUITO CONTROL DISTRICTS

§ 32.1-187. Counties, cities and towns may create mosquito control districts.

The governing body of any county, city or town, either alone or jointly with one or more other counties, cities or towns, may create one or more mosquito control districts. A mosquito control district may comprise the whole or any part of the county, city or town or combination thereof creating such district, except that no mosquito control district in a county shall include the territory within an incorporated town within such county except by agreement with such town.

Code 1950, § 32-379; 1950, p. 87; 1979, c. 711.

§ 32.1-188. Consolidation of districts.

The governing body of any city which has established more than one mosquito control district pursuant to § 32.1-187 may, by ordinance, consolidate such districts under a single commission which may function under the appropriate city department or other agency as determined by the local governing body.

Code 1950, § 32-379.1; 1973, c. 501; 1979, c. 711; 1981, c. 354; 2002, cc. 224, 233.

§ 32.1-189. Mosquito control commission; composition; appointment of members.

A. Each mosquito control district shall be administered by a commission of three members, one of whom shall be the Commissioner or his designee, except as provided for a consolidated city mosquito control commission in subsection B. The Commissioner or his designee shall serve as chairman of each such commission. Where a mosquito control district consists of territory wholly within one political subdivision, the governing body of that political subdivision shall appoint the other two members of the commission; where a mosquito control district shall consist of territory in two political subdivisions, the governing body of each such political subdivision shall appoint one member; and where any mosquito control district shall, by agreement between political subdivisions, consist of territory lying within more than two political subdivisions, the remaining two members of the commission for that district shall be appointed by the Commissioner from the residents of such district.

B. Notwithstanding the provisions of subsection A, in the event of consolidation of city mosquito control districts and commissions pursuant to § 32.1-188, such consolidated commission may consist of no more than fifteen commissioners, one of whom shall be the Commissioner or his designee who shall serve as the chairman of the consolidated city mosquito control commission.

Code 1950, § 32-380; 1979, c. 711; 2002, cc. 224, 233.

§ 32.1-190. Powers of commission; oath and terms of members; vacancies.

Each mosquito control commission district shall be a body politic and corporate and shall have all the powers necessary to carry into effect all of the provisions of this article. Each member of any such commission shall take and subscribe to the oath prescribed by § 49-1. The term of each commission member other than the Commissioner or his designee shall be four years and thereafter until his successor has been duly appointed and qualified. A vacancy other than by expiration of term shall be filled for the unexpired term by the authority originally making the appointment.

Code 1950, § 32-381; 1979, c. 711.

§ 32.1-191. Secretary of commission.

A mosquito control commission shall appoint its secretary either from the membership of such commission or otherwise and shall fix his compensation. The commission may require bond of its secretary in excess of the funds which may come into his hands and conditioned upon the faithful application of such funds.

Code 1950, § 32-382; 1979, c. 711.

§ 32.1-192. Further powers of commission.

Each mosquito control commission is empowered to employ all necessary personnel and to perform all acts necessary to control and eliminate mosquitoes in the district but such actions shall be subject to private property rights in the areas in which the work of the commission is performed.

Code 1950, § 32-383; 1979, c. 711.

§ 32.1-193. Eminent domain.

Each mosquito control commission is vested with the power of eminent domain to the extent necessary to carry out the provisions of this article. Condemnation proceedings shall be instituted and conducted in the name of the mosquito control commission for the district in which such property is located or the district for which its acquisition is deemed necessary and shall be conducted as prescribed by Chapter 2 (§ 25.1-200 et seq.) of Title 25.1.

Code 1950, § 32-384; 1979, c. 711; 2003, c. 940.

§ 32.1-194. Special tax authorized.

The governing body of any county, city or town, the whole or a part of whose territory is contained within a mosquito control district, is hereby authorized and empowered to levy annually a special tax upon all real and personal property subject to local taxation within the territory located within such county, city or town which is a part of such mosquito control district of not exceeding 25¢ per $100 of assessed valuation thereof, and all funds received from any tax levy so made shall be paid to the mosquito control commission for the mosquito control district in which the property subject to such levy is, and shall be expended by such mosquito control commission for the purposes authorized by this article.

Code 1950, § 32-385; 1979, c. 711.

§ 32.1-195. Contributions from Board.

The Board is hereby authorized to contribute annually to any mosquito control commission a sum not more than 25 percent of the gross amount obtained by such commission annually from any special tax levy authorized by this article or contributed to such commission annually by direct appropriation of any county, city, town or combination thereof, but any such amount so contributed by the Board shall not exceed $10,000 in any 1 year; except that where separate mosquito control commissions have been consolidated pursuant to § 32.1-188, such maximum amount shall be computed so as to allow a contribution to that consolidated district in an amount not less than was received prior to such consolidation by all of the separate districts.

Code 1950, § 32-386; 1974, c. 475; 1979, c. 711.

§ 32.1-196. Disposition of funds not needed for mosquito control.

Whenever funds accumulated by a mosquito control district are determined by the commission for such district to be no longer needed for the control of mosquitoes, such commission may transfer such funds as follows: (1) funds contributed by the Board, to the state treasury, (2) funds contributed by a county, city or town, to the treasury of such county, city or town, and (3) funds contributed by levy of a special tax upon property, to the treasury of the county, city or town wherein such property lies.

Code 1950, § 32-386.1; 1970, c. 391; 1979, c. 711.

§ 32.1-197. Compensation and expenses of members of commission.

The members of any mosquito control commission shall receive no salary for their services as such but shall receive necessary expenses incurred while actually engaged in discharge of their duties, to

be paid out of the funds under the control of such commission; provided, however, that if any member shall be appointed secretary for his commission, he may be paid, and shall be entitled to receive, such compensation as the commission may determine.

Code 1950, § 32-387; 1979, c. 711.

Article 5 - PUBLIC GATHERING PLACES

§ 32.1-198. Definitions.

As used in this article:

"Public gathering places" includes, but is not limited to:

(a) Historic shrines;

(b) Terminals of public transportation companies;

(c) Festivals, fairs, races and other places where 100 or more people congregate at one time.

Code 1950, § 32-63; 1979, c. 711; 1988, c. 60.

§ 32.1-199. Repealed.

Repealed by Acts 1988, c. 60.

§ 32.1-200. Regulations.

The Board may adopt such regulations governing toilet facilities, sewage disposal facilities and water supply facilities at public gathering places as may be necessary to protect the public health. Such regulations may include without limitation (i) a requirement that there be toilet facilities, sewage disposal facilities and water supply facilities and standards therefor; (ii) requirements that toilet facilities and all fixtures therein be kept clean and in a good state of repair; and (iii) a system of classifying public gathering places with different regulations for each such classification.

Code 1950, § 32-63; 1979, c. 711; 1988, c. 60.

§ 32.1-201. Free access to certain toilet facilities.

Public gathering places required by Board regulation to provide toilet facilities shall provide without charge at least one toilet for each sex.

Code 1950, § 32-63.2; 1977, c. 410; 1979, c. 711.

§ 32.1-202. Power of counties, cities and towns not limited.

Nothing contained in this article shall in any way limit the power of any county, city or town to regulate by ordinance sanitary conditions in service stations and public gathering places located therein, but no such ordinance may impose requirements less stringent than the regulations of the Board.

Code 1950, § 32-63; 1979, c. 711.

Article 6 - MIGRANT LABOR CAMPS

§ 32.1-203. Definitions.

As used in this article:

"Camp operator" means a person who has charge, care or control of a migrant labor camp.

"Migrant labor camp" or "camp" means one or more structures, buildings, tents, barracks, trailers, vehicles, converted buildings, and unconventional enclosures of living space, reasonably contiguous, together with the land appertaining thereto, established, operated or used as living quarters for one or more persons, one or more of whom is a migrant worker engaged in agricultural or fishing activities, including related food processing. "Migrant labor camp" does not include (i) a summer camp, campground or hotel as defined in § 35.1-1, (ii) housing which, in the ordinary course of business, is regularly offered to the general public on a commercial basis and is provided to any migrant worker on the same or comparable terms and conditions as provided to the general public, or (iii) small businesses which are exempt under federal law as provided in the Fair Labor Standards Act and the Migrant and Seasonal Worker Protection Act.

"Migrant worker" means any individual from within or outside the Commonwealth who passes seasonally from one place to another for the purpose of employment, who is not a year-round employee and who occupies living quarters other than his permanent home during the period of such work.

"Applicable regulations" includes regulations of the Board adopted pursuant to this article and occupational safety and health regulations applicable to migrant labor camps adopted by the Safety and Health Codes Board pursuant to Chapter 3 (§ 40.1-22 et seq.) of Title 40.1.

Code 1950, § 32-415; 1962, c. 251; 1979, c. 711; 1988, c. 632; 1990, c. 780; 1992, c. 15.

§ 32.1-204. Notice of intention to construct, etc., camp.

Each person planning to construct, substantially remodel or enlarge for occupancy or use a migrant labor camp or any portion or facility thereof, or to convert a property for use or occupancy as a camp shall give notice in writing of his intent to do so to the Commissioner at least thirty days before the date of beginning such construction, remodeling, enlargement or conversion. The notice shall give the name of the city or county in which the property is located, the location of the property within that area, a brief description of the proposed construction, remodeling, enlargement or conversion, the name and mailing address of the person giving the notice and his telephone number, if any. Upon receipt of such notice, the Commissioner shall forward to such person a copy of this article and any applicable regulations.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-205. Permit required.

No person shall operate or cause to be operated a migrant labor camp without a permit nor shall any person allow a migrant labor camp without a permit to be occupied and used on property owned or controlled by such person. A separate permit shall be required for each camp and shall be posted at a place in the camp readily visible and accessible to the migrant workers.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-206. Application for permit.

Application for a permit to operate a migrant labor camp shall be made to the Commissioner at least thirty days before such camp is to be opened on a form prescribed by the Board. A separate application shall be submitted for each camp.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-207. Inspection; issuance of permit; permits nontransferable.

If, after inspection by the Commissioner or his designee, the Commissioner finds that the camp or the proposed operation of the camp for which an application is submitted pursuant to § 32.1-206 conforms or will conform to the provisions of this article and any applicable regulations, the Commissioner shall issue a permit for the operation of the camp. A permit shall not be transferable and shall expire on December 31 of each year.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-208. Provisional permits.

When the Commissioner determines that a camp for which a permit is sought does not, or the proposed operation thereof will not, comply with the provisions of this article and any applicable regulations and that the operation of the camp will not create an imminent danger to the public health and safety, the Commissioner may grant a provisional permit to operate such a camp upon such terms, requirements, or conditions as the Commissioner may prescribe until the requirements of this article and any applicable regulations are fully complied with. The term of any such provisional permit shall not exceed thirty days. No provisional permit shall be renewable.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-209. Denial, revocation or suspension of permits.

A. The Commissioner may deny, revoke or suspend a permit for a camp when the Commissioner determines that the camp or the proposed operation thereof does not conform to or is in violation of any provision of this article or any applicable regulations.

B. A new permit shall be issued upon application therefor when the camp is in compliance with the provisions of this article and any applicable regulations.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-210. Camp operator's responsibilities.

The camp operator shall be responsible for ensuring that the camp complies with the provisions of this article, any applicable regulations and all conditions stated in the permit issued for the camp.

Code 1950, § 32-416; 1962, c. 251; 1979, c. 711.

§ 32.1-211. Regulations.

A. The occupational, safety and health regulations of the Safety and Health Codes Board applicable to migrant labor camps shall be no more stringent than those actually enforced by the United States Department of Labor pursuant to federal law.

B. The Board may adopt regulations governing migrant labor camps which supplement the occupational safety and health regulations adopted by the Safety and Health Codes Board pursuant to Chapter 3 (§ 40.1-22 et seq.) of Title 40.1 and which are necessary to protect the health of migrant workers. Such regulations may include, but need not be limited to, standards governing:

1. The sites of camps.

2. The provision of an adequate and convenient supply of pure water as defined in § 32.1-167.

3. The disposal of sewage as defined in § 32.1-163.

4. The storage and disposal of solid waste.

5. The maintenance of the campgrounds.

6. The construction, maintenance, alteration or remodeling of buildings and structures for the housing of migrant workers and their families, including wash and bathrooms, central cooking facilities, central dining rooms, sleeping quarters, assembly rooms, lighting and ventilation.

Code 1950, §§ 32-417, 32-418, 32-420; 1962, c. 251; 1968, c. 396; 1979, c. 711.

Article 7 - BEDDING AND UPHOLSTERED FURNITURE

§ 32.1-212. Definitions.

As used in this article unless the context otherwise requires:

"Bedding" means any mattress, mattress pad, box spring, upholstered bed, davenport, upholstered sofa bed, quilted pad, comforter, bolster, cushion, pillow, featherbed, sleeping bag, or any other bag, case or cover made of leather, textile or other material which is stuffed or filled in whole or in part with concealed substance, which can be used by any human being for sleeping or reclining purposes.

"Filling material" means cotton, wool, feathers, kapok, down, plant or vegetable fibers, or any other material or substance or combination thereof, loose or in batting, pads, or any prefabricated form, that is used or that may be used in articles of bedding or upholstered furniture.

"Importer" means any person who for the purpose of manufacture or resale receives bedding, upholstered furniture or filling material from any country other than the United States.

"New" means not previously used for any purpose. Manufacturing processes shall not be considered a prior use.

"Sanitize" means to reduce the level of microbiological agents to a level not injurious to health.

"Secondhand" means having been made prior use of or containing any filling material of which prior use has been made.

"Shoddy" means any material which has been spun into yarn, knit or woven into fabric and subsequently cut up, torn up, broken or ground up.

"Sterilize" means to render free of viable microbiological agents.

"Upholstered furniture" means any article of furniture designed to be used for sitting, resting, or reclining that is wholly or partly stuffed or filled with any filling material.

Code 1950, § 32-117; 1952, c. 530; 1956, c. 530; 1979, c. 711; 2005, c. 391.

§ 32.1-213. Shoddy, secondhand filling material, feathers, animal hair and down to be sanitized.

No person shall use in the making, remaking, reupholstering or renovating of any bedding or upholstered furniture any shoddy or any fabric from which shoddy is made or any secondhand filling material or any secondhand feathers, animal hair or down, unless such shoddy, secondhand filling material, feathers, hair or down has been sanitized by a reasonable process approved by the Commissioner.

Code 1950, § 32-118; 1952, c. 530; 1979, c. 711.

§ 32.1-214. New animal hair, feathers and down to be sterilized.

No person shall use in the making, remaking, reupholstering or renovating of any bedding or upholstered furniture any new animal hair, new feathers or new down unless such new animal hair, new feathers or new down shall have been sterilized by a reasonable process approved by the Commissioner.

1979, c. 711.

§ 32.1-215. Disposal restricted.

No person engaged in commerce shall rent, offer or expose for sale, barter, give away, or dispose of in any other commercial manner any article of bedding or upholstered furniture made, remade, reupholstered, or renovated in violation of § 32.1-213 or 32.1-214 or any secondhand article of bedding or upholstered furniture unless since last used such secondhand article has been sanitized by a reasonable process approved by the Commissioner. However, a retailer may sell, give away, or rent used upholstered furniture when the used upholstered furniture has been purchased by the retailer as new furniture and has been used in the course of business. Such used furniture shall be (i) conspicuously identified as used furniture and (ii) reduced in price, sold at auction, donated to charity, or made available for a rental fee, and so tagged.

Code 1950, § 32-119; 1952, c. 530; 1956, c. 530; 1979, c. 711; 2005, c. 391.

§ 32.1-216. Permit for use of process to sanitize or sterilize.

Any person applying for approval of a process by which filling materials, bedding or upholstered furniture are sanitized or sterilized shall submit to the Commissioner a description of the process and any apparatus and method to be used in such process. Upon approval of such process by the Commissioner and payment of the current annual permit fee by the applicant, a numbered permit for use of such process shall be issued. Such permit shall expire one year from the date of issue. Nothing herein shall prevent any person from having any sanitizing or sterilization required by this article performed by any person who has a valid permit for such purposes, provided the number of such permit appears on the tag attached to each article as required by § 32.1-219.

Code 1950, § 32-120; 1976, c. 317; 1979, c. 711.

§ 32.1-217. License and registration number; renewal; licenses not transferable; responsibility of branch factories.

A. Every importer and every person manufacturing, renovating or reupholstering any bedding or upholstered furniture or processing or selling any filling material to be used in articles of bedding or upholstered furniture shall first obtain a license from the Commissioner for each place of business, subsidiary or branch operated by him for such purpose. Such license shall be numbered, shall expire one year from the date of issue, shall be renewable annually unless sooner revoked and shall not be transferable. Each branch, branch factory and subsidiary shall be responsible for the contents and for the tagging, as provided in this article, of items of bedding and upholstered furniture made, remade, renovated, reupholstered or imported by it and offered for sale or use in the Commonwealth.

B. The Commissioner shall assign a registration number to each licensee.

Code 1950, § 32-120.1; 1954, c. 666; 1956, c. 530; 1970, c. 578; 1976, c. 317; 1979, c. 711.

§ 32.1-218. Fees.

The Board shall set the annual fees imposed for licenses and permits issued pursuant to this article. All fees collected shall be deposited and held by the Department in a separate fund, from which shall be paid all expenditures necessary in carrying out the provisions of this article.

Code 1950, § 32-120.1; 1954, c. 666; 1956, c. 530; 1970, c. 578; 1976, c. 317; 1979, c. 711.

§ 32.1-219. Tags required.

A. Every importer of and every person manufacturing a new item of bedding or upholstered furniture shall attach securely thereto a substantial white cloth tag or equivalent, visible on the outside covering of such item and not less than six square inches in size, upon which shall be plainly stamped or printed, in English, the name and address of the manufacturer, importer or distributor, the registration number of the manufacturer or importer, the kind of filling materials used therein, a statement that the filling materials are new, and the number of the permit issued to the person sterilizing any new feathers, hair or down in such item.

B. Any person sanitizing, remaking, renovating or reupholstering any secondhand item of bedding or upholstered furniture or manufacturing any item of bedding or upholstered furniture containing any shoddy or secondhand filling material shall attach securely to it a substantial yellow cloth tag or equivalent, visible on the outside of such item and not less than six square inches in size, upon which shall be stamped or printed, in English, the kind of filling materials used therein, a statement that the item or filling materials are secondhand, and the number of the permit issued to the person who sanitized such item or filling material.

C. The stamp or print on tags required by this section shall be in type not less than three millimeters in height.

Code 1950, § 32-122; 1952, c. 530; 1979, c. 711.

§ 32.1-220. Same; filling material.

Any person shipping or delivering filling material, however contained, shall have conspicuously attached thereto a tag upon which shall be stamped or printed, as provided in § 32.1-219 or as provided by the regulations of the Board, the kind of material, whether the material is new or secondhand, the name, address and registration number of the manufacturer or importer and the permit number of the person who sterilized or sanitized such material.

Code 1950, § 32-122.1; 1956, c. 530; 1979, c. 711.

§ 32.1-221. Offenses as to tags.

A. It shall be unlawful to use any false or misleading statement, term or designation on any tag required by this article or to remove, deface or alter, or to attempt to remove, deface or alter any such tag or the statement of filling materials made thereon, prior to retail sale.

B. No person shall use or have in his possession with intent to use any tag provided for in this article unless such person holds a license or permit issued to him pursuant to this article. No person shall sell, give or in any way provide such tags to anyone who does not have a license or permit issued to him pursuant to this article.

Code 1950, § 32-125; 1954, c. 666; 1979, c. 711.

§ 32.1-222. Return of improperly tagged items; payment of costs of return; failure to pay costs.

Upon a complaint made to the Commissioner as provided in § 32.1-224, the Commissioner may order the return of any item of bedding or upholstered furniture or any filling material made, remade, renovated, reupholstered, prepared, processed, tagged or not tagged in violation of the provisions of this article to the manufacturer or importer thereof. The manufacturer or importer shall be liable to the person returning such item for the costs of crating, shipping and the invoice price to the purchaser. Failure of a manufacturer or importer to pay such costs to the person returning such item shall be grounds for revocation or suspension of a license issued pursuant to this article.

1979, c. 711; 2003, c. 1003.

§ 32.1-223. New and sanitized items to be kept separate.

New and sanitized upholstered furniture, bedding and filling materials shall be kept separate from any secondhand upholstered furniture, bedding and filling materials that have not been sanitized.

1979, c. 711.

§ 32.1-224. Administration and enforcement by Commissioner; refusal, suspension or revocation of license or permit.

The Commissioner is charged with the administration and enforcement of this article, except as otherwise provided in this article. Only upon a complaint made to the Commissioner relating to a violation of this article may the Commissioner inspect the premises of a holder of a license or permit issued by the Commissioner. The Commissioner may refuse to issue, may suspend or may revoke the license or permit of any person (i) who violates any provision of this article, any regulation of the Board pursuant to this article or any order of the Board or Commissioner or (ii) who is not a resident of the

Commonwealth and fails or refuses to enter an appearance in any circuit court in the Commonwealth to answer a charge or charges of violation of any provision of this article, regulation of the Board or order of the Board or Commissioner within 25 days after service upon him of a notice by certified mail.

Code 1950, § 32-126; 1952, c. 530; 1979, c. 711; 2003, c. 1003.

§ 32.1-225. Exemptions.

A. The provisions of this article shall not apply to:

1. Any items of bedding or upholstered furniture sold under the order of any court or pursuant to § 55.1-2902, any sale of a decedent's estate, or any sale by any individual of his household effects.

2. Any items of bedding or upholstered furniture that are 75 years old or older.

3. Any interstate public carrier.

4. Any state institution, agency, or department unless such institution, agency, or department offers for sale to the public items of bedding or upholstered furniture manufactured, reupholstered, or renovated by it.

5. Any retailer who sells, gives away, or rents used upholstered furniture that has been purchased by the retailer as new furniture and has been used in the course of business when such used furniture has been (i) conspicuously identified as used furniture and (ii) reduced in price, sold at auction, donated to charity, or made available for a rental fee, and so tagged.

B. Any person who sells at retail, exclusively on a consignment basis, articles of bedding that are handmade by individuals and whose gross annual receipts from the sale of such articles are not in excess of $2,000 shall be deemed to be the manufacturer of such articles and shall not be required to obtain a license to make such articles. Each such article shall have a label affixed stating the kind of filling materials used in such article but shall be exempt from any other requirement as to tags set forth in this article.

Code 1950, § 32-127; 1979, c. 711; 1989, c. 130; 2001, c. 454; 2005, c. 391; 2023, cc. 374, 375.

§ 32.1-226. Violation a misdemeanor; application of the Virginia Consumer Protection Act.

A. Any person violating any provision of this article or any regulation of the Board adopted pursuant to this article shall be guilty of a Class 2 misdemeanor.

B. Additionally, any violation of the provisions of this article or regulations of the Board shall constitute a prohibited practice in accordance with § 59.1-200 and shall be subject to any and all of the enforcement provisions of the Virginia Consumer Protection Act (§ 59.1-196 et seq.).

Code 1950, § 32-129; 1952, c. 530; 1954, c. 666; 1956, c. 530; 1979, c. 711; 2003, c. 1003.

Article 8 - RADIATION CONTROL

§ 32.1-227. Definitions.

As used in this article unless the context requires a different meaning:

1. "By-product material" means:

a. Any radioactive material, except special nuclear material, yielded in or made radioactive by exposure to the radiation incident to the process of producing or utilizing special nuclear material;

b. The tailings or wastes produced by the extraction or concentration of uranium or thorium from any ore processed primarily of its source material content;

c. Any discrete source of radium-226 that is produced, extracted, or converted after extraction for use for a commercial, medical, or research activity;

d. Any material that has been made radioactive by use of a particle accelerator and is produced, extracted, or converted after extraction for use for a commercial, medical, or research activity; and

e. Any discrete source of naturally occurring radioactive material (NORM), other than source material that the Nuclear Regulatory Commission (NRC), in consultation with the Administrator of the Environmental Protection Agency, the Secretary of Energy, the Secretary of Homeland Security, and the head of any other appropriate federal agency, determines would pose a threat similar to the threat posed by a discrete source of radium-226 to the public health and safety or the common defense and security, that is extracted, or converted after extraction, for use for a commercial, medical, or research activity.

2. "General license" means a license effective under regulations promulgated by the Board without the filing of an application with the Department or the issuance of licensing documents to particular persons to transfer, acquire, own, possess, or use quantities of, or devices or equipment utilizing, radioactive material.

3. "Ionizing radiation" means gamma rays and X-rays, alpha and beta particles, high-speed electrons, neutrons, protons, and other nuclear particles.

4. "Person" means any individual, corporation, partnership, firm, association, trust, estate, public or private institution, group, department of the Commonwealth other than the Department of Health, political subdivision of the Commonwealth, any other state or political subdivision or department thereof, and any legal successor, representative, agent, or department of the foregoing, but not including federal government agencies.

5. "Radiation emergency" means any situation, excluding events resulting from nuclear warfare, which involves the possibility of accidental release of ionizing radiation that may pose a threat to the safety and health of any citizen of this Commonwealth.

6. "Radioactive material" means any material that emits ionizing radiation spontaneously.

7. "Source material" means uranium or thorium, or any combination thereof, in any physical or chemical form; or ores that contain by weight one-twentieth of one percent (0.05 percent) or more of uranium, thorium, or any combination thereof. Source material does not include special nuclear material.

8. "Special nuclear material" means (i) plutonium, uranium 233, uranium enriched in the isotope 233 or in the isotope 235, and any other material which the United States Nuclear Regulatory Commission or any successor thereto has determined to be such but does not include source material; or (ii) any material artificially enriched by any of the foregoing but not including source material.

9. "Specific license" means a license, issued to a named person upon application filed under the regulations promulgated pursuant to this article, to use, manufacture, produce, transfer, receive, acquire, or possess quantities of, or devices or equipment utilizing, radioactive material.

Code 1950, § 32-414.3; 1964, c. 158; 1975, c. 563; 1979, c. 711; 2008, cc. 41, 466.

§ 32.1-228. Exemption.

The provisions of this article shall not apply to radioactive materials or facilities, including nuclear reactors that are subject to exclusive licensing and regulation by the United States Nuclear Regulatory Commission.

Code 1950, § 32-414.7; 1964, c. 158; 1979, c. 711; 2008, cc. 41, 466.

§ 32.1-228.1. Department designated state radiation control agency; powers and duties.

A. The Department of Health is hereby designated as the state radiation control agency. The Commissioner of Health may employ, compensate, and prescribe the duties of such individuals as may be necessary to discharge the responsibilities imposed by this article.

B. The Department shall:

1. Collect and disseminate information relating to control of sources of radiation including:

a. Establishing and maintaining a file of all applications for, issuances, denials, transfers, renewals, modifications, suspensions and revocations of, and amendments to all licenses;

b. Establishing and maintaining a file of registrants possessing sources of radiation requiring registration under the provisions of this article and any administrative or judicial action pertaining thereto; and

c. Establishing and maintaining a file of all agency rules and regulations related to regulation of sources of radiation, pending or promulgated, and proceedings thereon.

2. Establish a database of registered and certified X-ray machines, which shall include but not be limited to the name of the owner or operator and the location of the machine.

3. Pursuant to its powers enumerated in § 32.1-25, provide for scheduled and random unannounced inspections of facilities and physicians' offices that provide mammography services to ensure compliance with laws, regulations, or conditions specified by the Board.

4. Establish forms for the periodic Radiation Inspection Report.

5. Develop programs for responding adequately to radiation emergencies and coordinate such programs with the Department of Emergency Management.

6. Make available to the public a list of persons who are certified as professionals to offer screening, testing, or mitigation for radon pursuant to § 32.1-229.01.

7. Publish and make available a list of qualified inspectors of X-rays and X-ray machines.

2008, cc. 41, 466; 2015, c. 298.

§ 32.1-229. Powers and duties of the Board.

The Board shall:

1. Establish a program of effective regulation of sources of radiation for the protection of the public health and safety, including a program of education and technical assistance relating to radon that is targeted to those areas of the Commonwealth known to have high radon levels. As a part of such program, a list of persons who are nationally certified to offer screening, testing, or mitigation for radon shall be made available to the public.

2. Establish a program to promote the orderly regulation of radiation within the Commonwealth, among the states and between the federal government and the Commonwealth and to facilitate intergovernmental cooperation with respect to use and regulation of sources of radiation to the end that duplication of regulation may be minimized.

3. Establish a program to permit maximum utilization of sources of radiation consistent with the public health and safety.

4. Promulgate regulations providing for (i) general or specific licenses to use, manufacture, produce, transfer, receive, acquire, own or possess quantities of, or devices or equipment utilizing, by-product, source, special nuclear materials, or other radioactive material occurring naturally or produced artificially, (ii) registration of the possession of a source of radiation and of information with respect thereto, and (iii) regulation of by-product, source and special nuclear material.

5. Encourage, participate in and conduct studies, investigations, training, research and demonstrations relating to control of sources of radiation.

6. Establish fee schedules for the licensure of radioactive materials.

7. Establish guidelines to require the licensed facilities or physicians' offices where mammography services are performed to offer to the patient, prior to departure, development of such films to ensure integrity and quality of the film. When film developing is not available or the patient chooses not to wait, the patient shall be notified within two business days if another mammogram is necessary. This requirement does not imply or require that a diagnostic opinion be made at the time of the mammogram. The interpreting physician may require that the mammogram be retaken if, in the opinion of the physician, the study is of inadequate quality. Such guidelines shall also require the licensed facility or physician's office where mammography services are performed to (i) include information on breast density in mammogram letters sent to patients pursuant to regulations implementing the Mammography Quality Standards Act promulgated by the U.S. Food and Drug Administration, and (ii) include in letters sent to patients determined by the interpreting physician to have heterogeneously dense or extremely

dense tissue, as defined in nationally recognized guidelines or systems for breast imaging reporting of mammography screening, including the Breast Imaging Reporting and Data System (BI-RADS) of the American College of Radiology, and any equivalent new terms, as such guidelines or systems are updated, the following notice:

"YOUR MAMMOGRAM DEMONSTRATES THAT YOU HAVE DENSE BREAST TISSUE. DENSE BREAST TISSUE IS VERY COMMON AND IS NOT ABNORMAL. HOWEVER, DENSE BREAST TISSUE CAN MAKE IT HARDER TO FIND CANCER ON A MAMMOGRAM AND MAY ALSO BE ASSOCIATED WITH AN INCREASED RISK OF BREAST CANCER.

THIS INFORMATION IS GIVEN TO YOU TO RAISE YOUR AWARENESS. USE THIS INFORMATION TO TALK TO YOUR DOCTOR ABOUT YOUR OWN RISKS FOR BREAST CANCER. AT THAT TIME, ASK YOUR DOCTOR IF MORE SCREENING TESTS MIGHT BE USEFUL BASED ON YOUR RISK.

A REPORT OF YOUR MAMMOGRAPHY RESULTS HAS BEEN SENT TO YOUR REFERRING PHYSICIAN'S OFFICE, AND YOU SHOULD CONTACT YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT THIS REPORT."

8. Issue such orders or modifications thereof as may be necessary in connection with proceedings under this title.

Code 1950, §§ 32-414.2, 32-414.4, 32-414.6, 32-414.7, 32-414.16; 1964, c. 158; 1968, c. 314; 1975, c. 563; 1979, c. 711; 1987, c. 666; 1988, c. 736; 1989, cc. 275, 283; 1999, c. 755; 2000, cc. 271, 936; 2001, cc. 408, 426; 2003, c. 635; 2008, cc. 41, 466; 2012, cc. 6, 125; 2013, c. 282; 2019, c. 279.

§ 32.1-229.01. Companies listed as proficient to perform radon screening, testing, or mitigation; compliance.

A. No person shall conduct or offer to conduct any radon screening, testing, or mitigation in the Commonwealth unless he (i) is listed as a professional by either the National Radon Proficiency Program or the National Radon Safety Board or (ii) meets any other proficiency measures deemed acceptable by the U.S. Environmental Protection Agency or the Board of Health for the purpose of offering such screening, testing, or mitigation.

B. Any person conducting or offering to conduct radon screening, testing, or mitigation in the Commonwealth pursuant to subsection A shall comply with (i) the radon testing standards outlined in the U.S. Environmental Protection Agency's publication EPA 402-R-92-003, as revised; (ii) the radon mitigation standards outlined in the American Society for Testing and Materials (ASTM International) Standard E-2121-13, as revised; or (iii) any other radon testing and mitigation standards deemed acceptable by virtue of reference by the U.S. Environmental Protection Agency or the Board.

1988, c. 736; 1989, cc. 275, 283; 2001, cc. 408, 426; 2003, c. 709; 2005, c. 839; 2008, cc. 41, 466; 2015, c. 298.

§ 32.1-229.01:1. Action for damages.

Any person who engages or otherwise uses the radon screening, testing, or mitigation services of a person misrepresenting his proficiency listing to conduct such services as described in § 32.1-229.01 may bring an action to recover the greater of (i) actual damages sustained, together with costs and reasonable attorneys' fees, or (ii) $100.

1993, c. 765.

§ 32.1-229.1. Inspections of X-ray machines required; Radiation Inspection Reports; fees; qualification of inspectors.

A. All X-ray machines shall be registered with the Department.

B. Every owner or operator of an X-ray machine shall request an initial inspection by a private inspector or a Department inspector no later than 30 days after the installation of the equipment.

Inspections shall be performed periodically on a schedule prescribed by the Board. The Department may also require random, unannounced, follow-up inspections of machines that were inspected by private inspectors in order to maintain quality control. In the event of changes in or installations of new equipment during the last 90 days of a period for which an inspection has been made, no interim inspection shall be required. In addition, the Department may require the inspection and certification of other machines emitting radiation or utilizing radiation for patients, consumers, workers, or the general public.

Inspections shall be performed by Department personnel or by private inspectors only. Inspections conducted by private inspectors shall be conducted in conformance with the regulations of the Board and reports on these inspections shall be filed by the registrant with the Department on forms prescribed by the Department. Results of all inspections shall be reviewed by the Department.

C. The Department shall issue a certificate for a diagnostic or therapeutic X-ray machine, or X-ray machine not used in the healing arts, when the results of the inspection indicate the machine meets the Board's standards. If the machine does not meet the Board's standards, the certification may be denied. If the certification is denied, the machine shall not be used for treatment, diagnosis, evaluation of patients, whether human or animal, or any other use until the standards of the Board have been met. A copy of the certificate shall be displayed by the registrant in a conspicuous place in close proximity to the X-ray machine.

D. The Board shall, in accordance with the Administrative Process Act (§ 2.2-4000 et seq.), promulgate such regulations as the Board deems necessary to protect the health and safety of health care workers, patients, and the general public, including but not limited to:

1. Fee schedules for registration of X-ray machines;

2. Schedule for inspections of X-ray machines;

3. Fee schedules for inspections of X-ray machines by Department personnel; however, no fee shall be charged for inspections initiated by the Department;

4. Standards for certification of X-ray machines; and

5. Qualifications for private inspectors of X-ray machines required for inclusion on a list of qualified inspectors of X-ray machines published pursuant to § 32.1-228.1, a requirement for annual registration as a private inspector of X-ray machines for inclusion on such list, and a fee not to exceed $150.00 for such registration.

E. The provisions of this section and of §§ 32.1-229 and 32.1-229.2 relating to X-ray machines and machines emitting or utilizing radiation shall not apply to devices purchased or used primarily for personal, family, or household purposes.

1987, c. 666; 2008, cc. 41, 466; 2016, c. 685.

§ 32.1-229.2. Costs of inspection conducted by Health Department; fees to be used to support program.

In order to minimize competition with the private sector, the fee schedule developed by the Board for routine inspections of X-ray machines by Department of Health inspectors shall include all reasonable costs of such inspections.

1987, c. 666; 2008, cc. 41, 466.

§ 32.1-229.3. Licensing of radioactive material.

A. All radioactive material not under the authority of the United States Nuclear Regulatory Commission, and devices or equipment utilizing such material, shall be licensed by the Board. The Board shall promulgate regulations that provide for general or specific licenses. The Board may require registration or licensing of any other source of radiation and may exempt certain sources of radiation, uses of radiation, or users of radiation from the licensing and registration requirements set forth in this article when the Commissioner finds that the exemption of such sources, uses, or users of radiation will not constitute a significant risk to the health and safety of the public. The terms and conditions of all licenses shall be subject to amendment, revision, or modification by rules, regulations, or orders issued in accordance with the provisions of this article.

B. Regulations promulgated under this article should provide for recognition of other Agreement State or federal licenses, subject to such requirements as the Board may prescribe.

C. It shall be unlawful for any person to use, manufacture, produce, distribute, sell, transport, transfer, install, repair, receive, acquire, own, or possess any source of radiation unless licensed by or registered with the Department in conformance with this article and any regulations promulgated by the Board pursuant to this article.

2008, cc. 41, 466.

§ 32.1-230. Further powers of Board.

The Board shall have the power, subject to the approval of the Governor:

1. To acquire by purchase, exercise of the right of eminent domain, grant, gift, devise or otherwise, the fee simple title to or any acceptable lesser interest in any lands, selected in the discretion of the Board as constituting necessary, desirable or acceptable sites for ionizing radiation control projects of the

Board, including any and all lands adjacent to a project site as in the discretion of the Board may be necessary or suitable for restricted areas; but in all instances lands which are to be designated as radioactive waste material sites shall be acquired in fee simple absolute and dedicated in perpetuity to such purpose.

2. To convey or lease, for such term as in the discretion of the Board may be in the public interest, any lands so acquired, either for a fair and reasonable consideration or solely or partly as an inducement to the establishment or location in the Commonwealth of any scientific or technological facility, project, satellite project or nuclear storage area; but subject to such restraints as may be deemed proper to bring about a reversion of title or termination of any lease in the event the grantee or lessee, as the case may be, shall cease to use the premises or facilities in the conduct of business or activities consistent with the purposes of this article; provided, however, radioactive waste material sites may be leased but may not otherwise be disposed of except to another department, agency or institution of the Commonwealth or to the United States.

3. To assume responsibility for perpetual custody and maintenance of radioactive materials held for custodial purposes at any publicly or privately operated facility located within the Commonwealth in the event the parties operating such facilities abandon their responsibility and whenever the federal government or any of its agencies has not assumed the responsibility. In such event, the Board may collect fees from private or public parties holding radioactive materials for perpetual custodial purposes in order to finance such perpetual custody and maintenance as the Board may undertake; provided, that the fees shall be sufficient in each individual case to defray the estimated cost of the Board's custodial management activities for that individual case. All such fees, when received by the Board, shall be credited to a special fund of the Department, shall be used exclusively for maintenance costs or for otherwise satisfying custodial and maintenance obligations and are hereby appropriated for such purpose.

4. To enter into an agreement with the federal government or any of its authorized agencies to assume perpetual maintenance of lands donated, leased, or purchased from the federal government or any of its authorized agencies and used for development of atomic energy resources or used as custodial sites for radioactive material.

Code 1950, § 32-414.4; 1964, c. 158; 1968, c. 314; 1975, c. 563; 1979, c. 711.

§ 32.1-231. Bonds of licensees.

A. The Board is authorized to require bonds of licensees. A bond shall be forfeited when the public health and safety is endangered by ionizing radiation due to the abandonment by a licensee of a licensed activity or licensed materials or due to a violation of law by a licensee. Each bond so forfeited shall be credited to a special fund on the books of the Department called the Radiation Reclamation Fund and shall be expended as necessary to restore to a safe condition the site where the licensed activity is or was conducted or the licensed materials are located.

B. The Board shall adopt regulations for determining the amount of each bond based upon the potential for contamination and injury by the licensed activity or material, the cost of disposal of the licensed material and the cost of restoring the site of the licensed activity to a safe condition.

C. No state, local or other governmental agency shall be required to file a bond. The Board may, by regulation, provide for the exemption of classes of licensees from bonding requirements if such classes present no significant risk to the public health and safety.

D. An acceptable bond for the purposes of this section shall be a bond issued by a fidelity or surety company authorized to do business in Virginia, a personal bond secured by such collateral as the Board may require or a cash bond.

Code 1950, § 32-414.4:1; 1976, c. 652; 1979, c. 711.

§ 32.1-232. Radioactive Material Perpetual Care Trust Fund.

A. The Board may require a licensee to deposit funds on an annual basis in a trust fund which shall be known as the Radioactive Material Perpetual Care Trust Fund, when the Board determines that it is probable that the licensee may cease to operate a licensed facility thereby leaving a site containing or associated with licensable radioactive material which will require maintenance, surveillance or other care on a continuing basis.

B. In order to provide for such maintenance, surveillance or other care, the Board may acquire any such site pursuant to § 32.1-230.

C. The Board may by lease with or license to any person provide for the maintenance, surveillance or other care of any such site. Any lessee or licensee operating under the provisions of this section shall be subject to § 32.1-231.

D. Each deposit of funds required of a licensee shall be in such amount that interest on the sum of all funds reasonably anticipated as payable by such licensee shall provide an annual amount equal to the anticipated reasonable costs necessary to maintain, monitor and otherwise supervise and care for the site as required in the interest of public health and safety. In arriving at the amount of funds to be deposited, the Board shall consider the nature of the licensed material, size and type of activity, estimated future receipts and estimated future expenses of maintenance, monitoring, and supervision.

E. All accrued interest on funds deposited in the Radioactive Material Perpetual Care Trust Fund is hereby appropriated to the Board and may be expended by the Board to acquire, monitor, maintain, supervise and care for such sites as required to protect the public health and safety on a continuing basis.

F. If a person licensed by any government agency other than the Commonwealth desires to transfer a site to the Board for the purpose of administering or providing perpetual care and if the Board accepts such transfer, a lump-sum deposit shall be made to the Perpetual Care Trust Fund. The amount of such deposit shall be determined by the Board taking into consideration the factors stated in subsection D of this section.

Code 1950, § 32-414.4:2; 1976, c. 652; 1979, c. 711.

§ 32.1-232.1. Special Trust Fund for Radioactive Materials Facility Licensure and Inspection created.

There is hereby created in the Department of the Treasury a special nonreverting fund known as the Special Trust Fund for Radioactive Materials Facility Licensure and Inspection, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller, and any moneys remaining in the Fund at the end of the biennium shall not revert to the general fund but shall remain in the Fund. All deposits of fees collected pursuant to subdivision 6 of § 32.1-229 shall be paid into the Department of the Treasury and credited to the Fund; in addition, the Fund shall consist of such funds as may be appropriated for the purpose of licensure and inspection of radioactive materials facilities, and such gifts, donations, grants, bequests, and other funds as may be received on its behalf. Interest earned on such moneys shall remain in the Fund and be credited to it. Moneys in the Fund shall be used solely to support the Department of Health's program for licensure and inspection of radioactive materials facilities as provided in this article and Board of Health regulations. Disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request of the Commissioner of Health.

1999, c. 755; 2008, cc. 41, 466.

§ 32.1-233. Radiation Advisory Board; composition; duties generally.

A. The Radiation Advisory Board shall consist of ten appointive members and the six ex officio members specified below. The Governor shall appoint to the Advisory Board individuals from industry, labor and agriculture as well as individuals with scientific training in one or more of the following fields: radiology, medicine, radiation or health physics, or related sciences, with specialization in ionizing radiation. Not more than two individuals shall be specialists in any one of the above-named fields. Members of the Advisory Board shall serve at the pleasure of the Governor. The Commissioner shall be an ex officio member and chairman of the Advisory Board. The Commissioner of Labor and Industry, the Commissioner of Agriculture and Consumer Services, the State Coordinator of Emergency Management, the Director of Environmental Quality, and the Director of the Virginia Institute of Marine Science shall be ex officio members of the Advisory Board.

B. The Advisory Board shall meet at least annually and shall:

1. Review and evaluate policies and programs of the Commonwealth relating to ionizing radiation; and

2. Make recommendations to the Commissioner and the Board of Health, the Director of Environmental Quality, and the Virginia Waste Management Board and furnish such technical advice as may be required, on matters relating to development, utilization and regulation of sources of ionizing radiation.

Code 1950, § 32-414.5; 1964, c. 158; 1979, c. 711; 1980, c. 728; 1985, c. 448; 1987, c. 157; 2008, cc. 41, 466.

§ 32.1-234. Repealed.

Repealed by Acts 1987, c. 666.

§ 32.1-234.1. Enforcement.

A. Whenever the Department finds, following inspection and examination, that a source of radiation as constructed, operated, or maintained results in a violation of this article or of any regulations promulgated pursuant to this article, the Department shall:

1. Notify the person in control of the source of radiation as to the nature of the violation; and

2. Specify a time frame for termination or abatement of the violation, including a deadline by which the source of the violation shall be reconstructed, operated, or maintained in compliance with this article and any regulations promulgated pursuant to this article.

B. Upon failure to comply with the time frame specified by the Department for termination or abatement of the violation, the Department may revoke the license, and pursue penalties or enforcement in accordance with § 32.1-27.

C. Whenever, in the judgment of the Department, any person has engaged in or is about to engage in any acts or practices that constitute or will constitute an emergency, hazard to health and safety, or a violation of any provision of this article or any rule, regulation, or order issued thereunder, and at the request of the Commissioner, the Attorney General may make application to the appropriate court for an order enjoining such acts or practices, or for an order directing compliance, and upon a showing by the Department that such person has engaged or is about to engage in any such acts or practices, a permanent or temporary injunction, restraining order, or other order may be granted.

D. In addition to the provisions of § 32.1-27, any person who violates the provisions of this article or any order or regulation adopted pursuant thereto shall, upon a finding by a court of competent jurisdiction, be assessed a civil penalty of not more than $10,000 for each day of such violation. All penalties arising under this section shall be recovered in a civil action brought by the Attorney General in the name of the Commonwealth. Civil penalties collected pursuant to this section shall be paid into the state treasury and credited to the Radioactive Material Perpetual Care Trust Fund created pursuant to § 32.1-232.

E. In addition to the provisions of § 32.1-25, the Department shall have the power to enter at all reasonable times, or in cases of an emergency, upon any private or public property for the purpose of determining whether or not there is compliance with or violation of the provisions of this article and rules and regulations issued thereunder, except that entry into areas under the jurisdiction of the federal government shall be effected only with the concurrence of the federal government or its duly designated representative.

2008, cc. 41, 466.

§ 32.1-235. Authority of Governor to enter into agreements with federal government; effect on federal licenses.

A. The Governor is authorized, subject to the appropriation of funds, to enter into agreements with the federal government providing for discontinuance of the federal government's responsibilities with respect to sources of ionizing radiation and the assumption thereof by this Commonwealth.

B. Any person who, on the effective date of an agreement under subsection A, except those exempted under § 32.1-228, possesses a license issued by the federal government shall be deemed to possess the same pursuant to this article. Such license shall expire either ninety days after receipt of a notice from the Department of expiration of such license or on the date of expiration specified in the federal license, whichever is earlier.

Code 1950, § 32-414.11; 1964, c. 158; 1974, c. 300; 1979, c. 711; 1999, c. 755; 2008, cc. 41, 466.

§ 32.1-236. Authority of Board to enter into agreements with federal government, other states or interstate agencies; training programs for personnel.

A. The Board, with the prior approval of the Governor, is authorized to enter into an agreement or agreements with the federal government, other states or interstate agencies, whereby this Commonwealth will perform, on a cooperative basis with the federal government, other states or interstate agencies, inspections or other functions relating to control of sources of ionizing radiation.

B. The Board, from funds provided by law, may institute programs for the purpose of training personnel to carry out the provisions of this article and, with the prior approval of the Governor, may make such personnel available for participation in any program or programs of the federal government, other states or interstate agencies in furtherance of this article.

Code 1950, § 32-414.12; 1964, c. 158; 1979, c. 711.

§ 32.1-237. Effect upon local ordinances, etc.

Ordinances, resolutions or regulations, now or hereafter in effect, of the governing body of a county or city relating to by-product, source and special nuclear materials shall not be superseded by this article, provided that such ordinances or regulations are and continue to be consistent with the provisions of this article, amendments thereto and regulations thereunder.

Code 1950, § 32-414.13; 1964, c. 158; 1979, c. 711.

§ 32.1-238. Impounding sources of ionizing radiation.

The Department is authorized, in the event of an emergency or under other circumstances constituting a hazard to health and safety, to impound or order the impounding of sources of ionizing radiation in the possession of any person who is not equipped to observe or fails to observe the provisions of this article or any regulations issued thereunder.

Code 1950, § 32-414.17; 1964, c. 158; 1979, c. 711; 2008, cc. 41, 466.

Article 8.1 - MID-ATLANTIC INTERSTATE LOW-LEVEL RADIOACTIVE WASTE COMPACT

§§ 32.1-238.1 through 32.1-238.5. Repealed.

Repealed by Acts 1986, c. 492.

Article 8.2 - SOUTHEAST INTERSTATE LOW-LEVEL RADIOACTIVE WASTE MANAGEMENT COMPACT

§ 32.1-238.6. Repealed.

Repealed by Acts 1983, c. 213.

§§ 32.1-238.6:1 through 32.1-238.10. Repealed.

Repealed by Acts 1988, c. 891.

Article 9 - Toxic Substances Information

§ 32.1-239. Definitions.

As used in this article the following definitions shall apply:

"Commercial establishment" means any commercial or industrial establishment, mill, factory, plant, refinery and any other works in which any chemical substance is manufactured or used as a raw material, catalyst, final product or process solvent for such; however, this term shall not be construed in the administration of this act to include normal farming and timbering activities.

"Manufacturing" means producing, formulating, packaging or diluting any substance for commercial sale or resale.

"Person" includes, in addition to the entities enumerated in § 32.1-3, the Commonwealth and any of its political subdivisions.

"Toxic substance" means any substance, including any raw materials, intermediate products, catalysts, final products, or by-products of any manufacturing operation conducted in a commercial establishment, that has the capacity, through its physical, chemical or biological properties, to pose a substantial risk of death or impairment either immediately or over time, to the normal functions of humans, aquatic organisms, or any other animal.

Code 1950, § 32-430; 1976, c. 627; 1977, c. 471; 1979, c. 711; 1984, c. 433; 1992, c. 203; 2020, c. 1271.

§ 32.1-240. Department designated state toxic substance information agency.

The State Department of Health is designated as the state toxic substances information agency. The Commissioner of Health may employ, compensate, and prescribe the administrative and clerical duties of such individuals as may be necessary to discharge the responsibilities imposed by this article.

Code 1950, § 32-431; 1976, c. 627; 1979, c. 711.

§ 32.1-241. Powers and duties of Board.

The Board shall:

1. Advise the Governor, other state agencies, the federal government, and local governing bodies on matters pertaining to chemical exposures posing a threat to public health or the environment;

2. Collect from any source, necessary information concerning substances which are toxic in certain concentrations and under certain conditions;

3. Catalogue information on substances that are toxic so that the information can be retrieved quickly for use;

4. Institute proceedings in any appropriate court to compel the production of information concerning substances which are toxic;

5. Review and evaluate the information to be used in making a determination regarding toxicity of any substance and the concentrations and conditions under which the substance is toxic;

6. Disseminate information concerning toxic substances to other state agencies, political subdivisions of the Commonwealth, health professionals, the media, and the public by communicating the risk of chemical exposure through developing and disseminating documents, technical reports, information sheets, advisories, and press releases;

7. Investigate potential human health effects associated with environmental exposures through biomedical studies to address emergency and nonemergency site-specific problems;

8. Develop health risk assessments for specific chemical exposures via air, water, and food; coordinate assessments of such risks with other state agencies through the convening of assessment groups; and submit recommendations to prevent exposure of citizens to toxic substances, including, but not limited to, the closure of bodies of water and advisories relating to food consumption; and

9. Promulgate regulations to specify as necessary the details of the program.

Code 1950, §§ 32-428.1, 32-429; 1976, c. 627; 1977, c. 471; 1979, c. 711; 1982, c. 16; 1992, c. 203; 1995, c. 90.

§ 32.1-242. Repealed.

Repealed by Acts 1995, c. 90.

§ 32.1-243. State agencies directed to cooperate with and furnish information to Board.

All agencies and institutions of the Commonwealth shall cooperate with the Board and, on request, furnish to the Board all information in their possession concerning toxic substances.

Code 1950, § 32-434; 1976, c. 627; 1979, c. 711; 1992, c. 203.

§ 32.1-244. Duty of operators to report knowledge of toxicity; retention and return of certain information; diagnosis of employee injuries and illnesses.

Each person who operates a commercial establishment that uses as a raw material, catalyst, final product or process solvent or manufactures any chemical or mixture in a manner that the person knows, or reasonably should know, is toxic and under the circumstances of its manufacture or use

may pose a substantial threat to human health or to the environment shall have the affirmative duty to report that information to the Board within five days of receiving it.

In discharging this duty to report, each person shall have the further affirmative duty to make reasonable inquiry into the toxicity of any substance. Any knowledge of toxicity that is possessed by an employee or agent of the person, or by the holder of any patent under which the person is licensed to produce such substance, shall be attributed to that person if the person actually received that knowledge or, in the exercise of due diligence of such person, should have received that knowledge. Any knowledge of toxicity that is possessed by any consultant or independent contractor, who has been retained by the person to perform any evaluation or other task which involves any such substance, shall be attributed to the person if such person actually received that knowledge or, in the exercise of due diligence by such person, should have received that knowledge.

Except as provided in this section, the Board shall not require any reports by operators of commercial establishments to be filed pursuant to this article unless the Board can demonstrate that the report is necessary to prevent or lessen an imminent risk of injury to public health or the environment.

Each person who operates a commercial establishment in which any chemical is manufactured or is used as a raw material, catalyst, final product or process solvent shall direct each of his employees to a physician for diagnosis of any injury or illness of any kind whatever that the person knows, or reasonably should know, may be caused by such chemical. Nothing in this article shall be deemed, however, to authorize or require physical examination or medical treatment for any person who objects thereto on religious grounds.

The Department shall make reasonable efforts to return all confidential business information filed pursuant to this article to the owner or operator of the business that reported it; however, if the business no longer exists or the owner or operator cannot be located, the Department may retain the confidential information under the same terms and conditions of confidentiality existing prior to July 1, 1992, or, at the discretion of the Commissioner, purge and destroy such information.

Code 1950, § 32-435.1; 1977, c. 471; 1979, c. 711; 1982, c. 16; 1984, c. 433; 1992, c. 203.

§ 32.1-244.1. Repealed.

Repealed by Acts 1992, c. 203.

§ 32.1-245. Toxic substances.

The Board shall advise the General Assembly and the Governor as to all matters relating to toxic substances in the Commonwealth.

Code 1950, § 32-438; 1976, c. 627; 1979, c. 711; 1984, c. 433; 1992, c. 203; 2008, c. 671.

Article 10 - MISCELLANEOUS PROVISIONS

§ 32.1-246. Marinas.

A. The Board is empowered and directed to adopt and promulgate all necessary regulations establishing minimum requirements for adequate sewerage facilities at marinas and other places where

boats are moored according to the number of boat slips and persons such marinas and places are designed to accommodate. The provisions of this section shall be applicable to every such marina and place regardless of whether such establishment serves food.

B. The Commissioner shall enforce the provisions of this section and regulations adopted thereunder.

C. No such marina or place shall operate unless in accordance with this section and regulations adopted and promulgated thereunder.

D. Whenever the Commissioner shall have approved the plan for the sewerage facilities of a proposed marina for presentation to the Marine Resources Commission as provided in § 62.1-3, he shall have the power and duty to enforce compliance with such plan.

Code 1950, § 32-63.1; 1968, c. 594; 1979, c. 711.

§ 32.1-246.1. Signs or notices required on dump stations.

Any marina required to have a dump station pursuant to the regulations of the Board of Health shall clearly identify or placard such equipment by signs or other notices, indicating any fees, restrictions or other operating instructions as necessary.

1991, c. 32.

§ 32.1-247. Vector control.

The Board shall develop and maintain the capability and technical competence necessary to investigate the occurrence of diseases borne by insects and rodents and shall recommend such measures as may be necessary to prevent the spread of such diseases and to eradicate or control disease-bearing insects and rodents.

In this regard the Board shall make provision for assistance to mosquito control commissions when requested, field surveys and investigation of complaints, advice to citizens and local governments, training in vector control, advice and recommendations on proper use of pesticides, and identifying specimens.

1979, c. 711; 1985, c. 372.

§ 32.1-248. Closing of waters; modification or revocation of regulation or order.

The Board may adopt regulations or orders closing any river, stream, lake or other body of water in this Commonwealth to fishing, boating, swimming or any other usage if the Board finds, and states the reasons and precise factual basis for finding, that a toxic substance as defined in § 32.1-239 is present in such river, stream, lake or other body of water in such manner as to constitute a present threat to public health and welfare. Such regulation or order may be temporary or permanent and may be issued initially on an emergency basis. Thereafter it may be promulgated as a final regulation or order upon the completion by the Board of the procedural requirements set forth in the Administrative Process Act (§ 2.2-4000 et seq.).

If the Commissioner determines that the threat to public health and welfare has abated in whole or in part, the State Health Commissioner may modify or revoke any such regulation or order in a manner

that lessens the restrictions placed upon fishing, boating, swimming, or other usage. Such modification or revocation by the Commissioner shall not be subject to the requirements of the Administrative Process Act but shall be filed with the Registrar of Regulations in accordance with § 2.2-4103. The Board shall review such modification or revocation at its next regularly scheduled meeting after such action by the Commissioner and shall affirm, reverse, or modify the Commissioner's action. Review by the Board shall also be exempt from the provisions of the Administrative Process Act.

1979, c. 711; 1981, c. 144.

§ 32.1-248.01. Fish consumption advisories.

The Virginia Department of Health shall develop a written policy, which shall be revised annually, that identifies the criteria and levels of concern for certain toxic substances that the Department will use in determining whether to issue a fish consumption advisory. The policy shall initially include the criteria and levels of concern for polychlorinated biphenyl, mercury, dioxin, and kepone. The Department shall issue fish consumption advisories as provided for in the policy and shall do so on a timely basis. A copy of the written policy shall be provided to the Chairmen of the House Committee on Health, Welfare and Institutions, the House Committee on Conservation and Natural Resources, the Senate Committee on Education and Health, and the Senate Committee on Agriculture, Conservation and Natural Resources no later than one month prior to adoption of the policy but no later than December 1, 2000. Any revision of the policy shall be submitted to the chairmen of these committees no later than one month prior to the adoption of the revision by the Department.

2000, cc. 17, 1043.

§ 32.1-248.1. Posting of water quality test results by certain recreational facilities.

The Board of Health shall promulgate regulations to require the daily posting of water quality test results at swimming pools and other water recreational facilities operated for public use or in conjunction with a tourist facility or health spa. Such regulations shall require, among other things, the posting of water quality data regarding the current pH level, disinfectant type and concentration, and water temperature, and the recommended safe levels of each, and shall not apply to private residential water recreational facilities, as defined by the Board.

1990, c. 812.

§ 32.1-248.2. Use of rainwater and reuse of gray water; regulations.

A. The Board shall adopt regulations regarding the use of gray water and rainwater. The regulations shall (i) describe the conditions under which gray water and rainwater may appropriately be used and for what purposes; (ii) include categories of gray water, such as types of used household water and used water from businesses, that are appropriate for reuse; and (iii) include a definition of gray water that excludes used toilet water. The regulations shall also provide standards for the use of rainwater harvesting systems, including systems that collect rainwater for use by commercial enterprises but do not provide water for human consumption, as defined in § 32.1-167.

Such regulations shall not apply to water not for human consumption, as defined in § 32.1-167, including gray water and rainwater, that is produced and utilized by any facility that is permitted through a Virginia Pollutant Discharge Elimination System permit or General Virginia Pollution Abatement permit.

B. The Department, in conjunction with the Department of Environmental Quality, shall promote the use of rainwater and reuse of gray water as means to reduce fresh water consumption, ease demands on public treatment works and water supply systems, and promote conservation.

C. The Department, in conjunction with the Department of Environmental Quality, shall consider recognizing rainwater as an independent source of fresh water available for use by the residents of the Commonwealth.

1998, c. 155; 2018, c. 817.

§ 32.1-248.3. Environmental Health Education and Training Fund.

There is hereby created the Environmental Health Education and Training Fund, whose purpose is to receive moneys generated by the civil penalties collected by the Department pursuant to § 32.1-164 and appropriated by the Commonwealth for the purpose of supporting, training, educating, and recognizing public- and private-sector individuals in all areas of environmental health, including licensed onsite soil evaluators and Department employees. Civil penalties collected by the Department shall be deposited by the Comptroller to this fund to be appropriated for the purposes of this section to the Department by the General Assembly as it deems necessary. The fund may also be used, in the discretion of the Board, for research to improve public health and for protection of the environment.

2007, c. 514; 2016, c. 90.

§ 32.1-248.4. Provision by the Department of certain services for onsite sewage systems and private wells.

A. The Department shall take steps to eliminate evaluation and design services provided by the Department for onsite sewage systems and private wells. In taking such steps, the Department shall:

1. Accept private evaluations and designs for private wells, in compliance with the State Board of Health regulations for construction of private wells, designed and certified by a certified master water well system provider pursuant to § 54.1-1129.1;

2. Cease providing onsite sewage system evaluations and design services that are not associated with a building permit or the repair of a failing sewage system. Hardship exceptions shall not apply to these services;

3. Cease providing new construction evaluation and design services for an application that is not for a principal place of residence. Hardship exceptions shall not apply to these services;

4. By July 1, 2019, establish guidelines to maintain the Department as a provider of last resort for a property owner who demonstrates a specific hardship in obtaining private sector evaluation and design services associated with a building permit or the repair of a failing sewage system that is for a principal place of residence. In developing such guidelines, the Department shall solicit and consider

input from stakeholders. The Department's guidelines shall include considerations for hardships based on (i) the availability of properly licensed service providers working within a locality or region, (ii) the disciplinary history of private sector providers, and (iii) the cost of private sector services. The Department shall post its proposed guidelines on a website maintained by the Department by November 1, 2018; and

5. Beginning July 1, 2019, require an applicant for an onsite sewage system or private well construction permit who desires the Department to provide evaluation and design services associated with a building permit or the repair of a failing sewage system that is for a principal place of residence to petition the Department to provide such evaluation and design services.

B. The Department shall coordinate with the Department of Professional and Occupational Regulation to establish any necessary agreements or procedures to ensure that potential violations of laws or regulations regarding onsite sewage system and private well evaluation and design are referred to the appropriate agency or board for review.

2018, c. 831.

Chapter 7 - Vital Records

Article 1 - Definitions and Administrative Provisions

§ 32.1-249. Definitions.

As used in this chapter:

"Dead body" means a human body or such parts of such human body from the condition of which it reasonably may be concluded that death occurred.

"Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, regardless of the duration of pregnancy; death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

a. "Induced termination of pregnancy" means the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth.

b. "Spontaneous fetal death" means the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy.

"File" means the presentation of a vital record provided for in this chapter for registration by the Department.

"Final disposition" means the burial, interment, cremation, removal from the Commonwealth or other authorized disposition of a dead body or fetus.

"Institution" means any establishment, public or private, which provides inpatient medical, surgical, or diagnostic care or treatment, or nursing, custodial or domiciliary care, or to which persons are committed by law.

"Live birth" means the complete or substantial expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. As used in this definition, "substantial expulsion or extraction" means, in the case of a headfirst presentation, the infant's entire head is outside the body of the mother or, in the case of a breech delivery, when any part of the infant's trunk past the navel is outside the body of the mother.

"Physician" means a person authorized or licensed to practice medicine or osteopathy in this Commonwealth.

"Registration" means the acceptance by the Department and the incorporation of vital records as provided for in this chapter into its official records.

"System of vital records" means the registration, collection, preservation, amendment, and certification of vital records; the collection of other reports required by this chapter; and related activities.

"Vital records" means certificates or reports of births, deaths, fetal deaths, adoptions, marriages, divorces or annulments and amendment data related thereto.

Code 1950, § 32-353.4; 1960, c. 451; 1975, c. 267; 1979, c. 711; 1983, c. 240; 2003, cc. 961, 963; 2020, c. 922.

§ 32.1-250. Duties of Board.

A. The Board shall install, maintain and operate the only system of vital records throughout this Commonwealth.

B, C. [Repealed.]

Code 1950, §§ 32-353.5, 32-353.6; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-251. State Registrar; appointment.

The Commissioner shall appoint a State Registrar of Vital Records hereinafter referred to as "State Registrar."

Code 1950, § 32-353.7; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-252. State Registrar; duties; delegations.

A. The State Registrar, under the supervision of the Commissioner, shall:

1. Administer the provisions of this chapter and the regulations of the Board in a manner that will ensure the uniform and efficient administration of the system of vital records.

2. Direct and supervise the system of vital records and be custodian of its records.

3. Direct, supervise and control the activities of all persons when pertaining to the operation of the system of vital records.

4., 5. [Repealed.]

6. Conduct training programs to promote uniformity of policy and procedures throughout the Commonwealth in matters pertaining to the system of vital records.

7. Inspect vital records which have been sealed as provided by law whenever such inspection will facilitate the administration of this chapter without violating the confidentiality of such records.

8. Perform such other duties as may be required by law.

9. Develop, furnish and distribute, in accordance with the regulations of the Board, forms as required by this chapter and such other means for transmission of data as may be necessary for the purpose of complete and accurate reporting and registration.

10. Develop and provide a means for obtaining a social security number in conjunction with the issuance of a birth certificate.

11. Develop, furnish and distribute a surrogate consent and report form as described in § 20-162.

B. The State Registrar may delegate functions and duties vested in him to designated assistants and to county, city and special registrars as he deems necessary or expedient.

C. The Department of Motor Vehicles, when issuing a certified copy of a vital record, shall be subject to the State Registrar's rules, regulations, and audit requirements, including the provisions of this chapter.

Code 1950, § 32-353.8; 1960, c. 451; 1979, c. 711; 1983, c. 240; 1990, c. 576; 2000, c. 890; 2013, c. 534.

§ 32.1-253. Same; establishment of registration districts.

The State Registrar shall from time to time establish registration districts throughout the Commonwealth. He may consolidate or subdivide such districts to facilitate registration.

Code 1950, § 32-353.9; 1960, c. 451; 1979, c. 711.

§ 32.1-254. County and city registrars designated; deputies; special registrars.

A. Each county and city health director shall be the county or city registrar of vital records and health statistics for his jurisdiction and shall appoint one or more deputies in the county or city health department. Any county or city registrar may recommend that the State Registrar appoint a special registrar when necessary to facilitate registration in his county or city.

B. When there is no duly appointed county or city health director, the State Registrar shall appoint a county or city registrar to serve pending the appointment of a health director.

Code 1950, § 32-353.10; 1960, c. 451; 1979, c. 711.

§ 32.1-255. Duties of county, city and special registrars and deputies.

A. The county, city or special registrar with respect to his jurisdiction shall:

1. Perform his duties pursuant to the provisions of this chapter and regulations issued hereunder.

2. Transmit twice monthly the certificates, reports, or other records filed with him to the State Registrar or more frequently when directed to do so by the State Registrar.

3. Maintain such local records, make such reports and perform such other duties as may be required by the State Registrar.

B. Deputies shall perform the duties of the registrar in the absence or incapacity of such registrar and shall perform such other duties as may be prescribed by the State Registrar.

Code 1950, § 32-353.11; 1954, c. 346; 1960, c. 451; 1979, c. 711.

§ 32.1-256. Fees of special registrars.

A. Each special registrar not employed by any federal, state or local agency shall be paid the sum of one dollar for each certificate of birth, death or fetal death registered by him and transmitted to the county or city registrar of vital records.

B. If no birth, death or fetal death is registered by him during any calendar month, such special registrar shall report that fact to the county or city registrar of vital records and shall be paid the sum of one dollar for each such month.

C. The State Registrar shall certify to the treasurer of the county or city quarterly the number of birth, death and fetal death certificates registered by such special registrar, with the name of such special registrar and the amount due. Upon such certification, the fees due such special registrar shall be paid by the treasurer of the appropriate county or city.

Code 1950, §§ 32-353.12, 32-353.13; 1952, c. 705; 1952, Ex. Sess., c. 22; 1960, c. 451; 1979, c. 711; 1983, c. 240.

Article 2 - Birth Certificates

§ 32.1-257. Filing birth certificates; from whom required; signatures of parents.

A. A certificate of birth for each live birth that occurs in the Commonwealth shall be filed with the State Registrar within seven days after such birth. The certificate of birth shall be registered by the State Registrar if it has been completed and filed in accordance with this section.

B. When a birth occurs in an institution or en route thereto, the person in charge of such institution or an authorized designee shall obtain the personal data, and prepare the certificate either on forms furnished by the State Registrar or by an electronic process as approved by the Board. Such person or designee shall, if submitting a form, secure the signatures required by the certificate. The physician or other person in attendance shall provide the medical information required by the certificate within five days after the birth. The person in charge of the institution or an authorized designee shall certify to the authenticity of the birth registration either by affixing his signature to the certificate or by an elec-

tronic process approved by the Board, and shall file the certificate of birth with the State Registrar within seven days after such birth.

C. When a birth occurs outside an institution, the certificate shall be prepared on forms furnished by the State Registrar and filed by one of the following in the indicated order of priority, in accordance with the regulations of the Board:

1. The physician in attendance at or immediately after the birth, or in the absence of such physician,

2. Any other person in attendance at or immediately after the birth, or in the absence of such a person,

3. The mother, the other parent, or, in the absence of the other parent and the inability of the mother, the person in charge of the premises where the birth occurred.

C1. When a birth occurs on a moving conveyance within the United States of America and the child is first removed from the conveyance in this Commonwealth, the birth shall be registered in this Commonwealth and the place where the child is first removed from the conveyance shall be considered the place of birth. When a birth occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the child is first removed from the conveyance in this Commonwealth, the birth shall be registered in this Commonwealth although the certificate shall indicate the actual place of birth insofar as can be determined.

D. If the mother of a child is not married to the natural father of the child at the time of birth or was not married to the natural father at any time during the 10 months next preceding such birth, the name of the father shall not be entered on the certificate of birth without a sworn acknowledgment of paternity, executed subsequent to the birth of the child, of both the mother and of the person to be named as the father. In any case in which a final determination of the paternity of a child has been made by a court of competent jurisdiction pursuant to § 20-49.8, from which no appeal has been taken and for which the time allowed to perfect an appeal has expired, the name of the father and the surname of the child shall be entered on the certificate of birth in accordance with the finding and order of the court.

Children born of marriages prohibited by law, deemed null or void, or dissolved by a court shall nevertheless be legitimate and the birth certificate for such children shall contain full information concerning the other parent.

For the purpose of birth registration in the case of a child resulting from assisted conception, pursuant to Chapter 9 (§ 20-156 et seq.) of Title 20, the birth certificate of such child shall contain full information concerning the mother's spouse as the other parent of the child and the gestational mother as the mother of the child. Donors of sperm or ova shall not have any parental rights or duties for any such child.

In the event that any person desires to have the name of the father entered on the certificate of birth based upon the judgment of paternity of a court of another state, such person shall apply to an appropriate court of the Commonwealth for an order reflecting that such court has reviewed such judgment

of paternity and has determined that such judgment of paternity was amply supported in evidence and legitimate for the purposes of Article IV, Section 1 of the Constitution of the United States.

If the order of paternity should be appealed, the registrar shall not enter the name of the alleged father on the certificate of birth during the pendency of such appeal. If the father is not named on the certificate of birth, no other information concerning the father shall be entered on the certificate.

E. Either of the parents of the child shall verify the accuracy of the personal data to be entered on the certificate of birth in time to permit the filing within the seven days prescribed above.

Code 1950, § 32-353.15; 1960, c. 451; 1979, c. 711; 1983, c. 240; 1984, c. 189; 1991, c. 611; 1994, cc. 796, 919; 2020, c. 900.

§ 32.1-257.1. Parents to report social security account number at time of child's birth.

Pursuant to 42 U.S.C. § 405, as amended, the social security account number of each parent shall be reported in the manner prescribed and on forms furnished by the State Registrar.

1991, c. 95.

§ 32.1-258. Report of foundling; constitutes birth certificate.

A. Whoever assumes the custody of a living infant of unknown parentage shall report on a form and in the manner prescribed by the Board within seven days to the registrar of the county or city in which such child was found, the following information:

1. The date and place of finding;

2. Sex, race and approximate birth date of such child;

3. Name and address of the persons or institution with whom such child has been placed for care;

4. Name given to such child by the custodian of the child; and

5. Such other data as may be required by the Board.

B. The place where such child was found shall be entered as the place of birth.

C. A report registered under this section shall constitute the certificate of birth for such infant.

D. If such child is identified and a certificate of birth is found or obtained, any report registered under this section shall be sealed and filed and may be opened only by order of a circuit court of the Commonwealth or in accordance with subdivision A 7 of § 32.1-252.

Code 1950, § 32-353.16; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-258.1. Certificate of Birth Resulting in Stillbirth; requirements.

Upon the request of either individual listed as the parent on a report of fetal death in the Commonwealth as defined in § 32.1-264, the State Registrar shall issue a Certificate of Birth Resulting in Stillbirth for unintended, intrauterine fetal deaths occurring after a gestational period of 20 weeks or more. The requesting parent may, but shall not be required to, provide a name for the stillborn child on the Certificate of Birth Resulting in Stillbirth. This section shall apply retroactively to any

circumstances that would have resulted in the issuance of a Certificate of Birth Resulting in Stillbirth, as prescribed by the Board.

2003, cc. 537, 552; 2020, c. 900; 2022, c. 171.

§ 32.1-259. Filing and registration of delayed birth certificates; refusal of registration; notice of right of appeal.

A. When the birth of a person born in this Commonwealth has not been registered, a certificate may be prepared and filed in accordance with regulations of the Board. Such certificate shall be registered subject to such documentary evidence requirements as the Board shall by regulation prescribe to substantiate the alleged facts of birth.

B. A certificate of birth registered one year or more after the date of birth shall be recorded on forms prescribed and furnished by the Board, marked "Delayed" and shall show on the face the date of the delayed registration.

C. A summary statement of the evidence submitted in support of the delayed registration shall be endorsed on the certificate.

D. 1. When an applicant does not submit the documentation required in the regulations for delayed registration or when the State Registrar finds reason to question the validity or adequacy of the proposed certificate or the documentary evidence, if the deficiencies are not corrected, the State Registrar shall not register the delayed certificate of birth and shall notify the applicant of the reasons for this action and shall also advise the applicant of his right to petition for a court order pursuant to § 32.1-260.

2. The Board may by regulation provide for the dismissal of an application which is not actively pursued.

Code 1950, § 32-353.17; 1954, c. 201; 1956, c. 260; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-260. Petition for court order establishing record of birth when delayed certificate rejected; hearing; notice; findings; registration of court order.

A. If a delayed certificate of birth is rejected under the provisions of § 32.1-259, a petition for an order establishing a record of the date and place of the birth and the parentage of the person whose birth is to be registered may be filed with the circuit court of the county or city in which the person resides; or if the person is a citizen of this Commonwealth without a fixed residence or a resident of another state, the petition may be to the circuit court of the county or city in which such person's birth occurred. In case of a minor who has no parent or guardian, the application may be made by his next friend.

B. Such petition shall allege:

1. That the person for whom a delayed certificate of birth is sought was born in this Commonwealth;

2. That no record of birth of such person can be found in the records of the State Registrar or the county or city registrar;

3. That diligent efforts by the petitioner have failed to obtain the evidence required by regulations pursuant to § 32.1-259; and

4. That the State Registrar has refused to register a delayed certificate of birth; and

5. Such other allegations as may be required.

C. The petition shall be accompanied by the notice of the State Registrar made in accordance with subdivision D 1 of § 32.1-259 and all documentary evidence which was submitted to the State Registrar in support of such registration.

D. The court shall fix a time and place for hearing the petition and the petitioner shall give the State Registrar five days' notice of said hearing. The State Registrar, or his authorized representative, may appear and testify in the proceeding.

E. If the court finds from the evidence presented that the person for whom a delayed certificate of birth is sought was born in this Commonwealth, it shall make findings as to the place and date of birth, parentage, and such other findings as may be required and shall issue an order to establish a record of birth on a form furnished by the State Registrar. This order shall include the birth data to be registered, a description of the evidence presented in the manner prescribed by § 32.1-259, and the date of the court's action.

F. The clerk of court shall forward each such form to the State Registrar not later than the tenth day of the calendar month following the month in which the order was entered. Such form shall be registered by the State Registrar and shall constitute the certificate of birth, from which certifications may be issued in accordance with § 32.1-272.

Code 1950, § 32-353.18; 1954, c. 201; 1956, c. 260; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-261. New certificate of birth established on proof of adoption, legitimation or determination of paternity, or change of sex.

A. The State Registrar shall establish a new certificate of birth for a person born in the Commonwealth upon receipt of the following:

1. An adoption report as provided in § 32.1-262, a report of adoption prepared and filed in accordance with the laws of another state or foreign country, or a certified copy of the decree of adoption together with the information necessary to identify the original certificate of birth and to establish a new certificate of birth; except that a new certificate of birth shall not be established if so requested by the court decreeing the adoption, the adoptive parents, or the adopted person if 18 years of age or older.

2. A request that a new certificate be established and such evidence as may be required by regulation of the Board proving that such person has been legitimated or that a court of the Commonwealth has, by final order, determined the paternity of such person. The request shall state that no appeal has been taken from the final order and that the time allowed to perfect an appeal has expired.

3. An order entered pursuant to subsection D of § 20-160. The order shall contain sufficient information to identify the original certificate of birth and to establish a new certificate of birth in the names of the intended parents.

4. A surrogate consent and report form as authorized by § 20-162. The report shall contain sufficient information to identify the original certificate of birth and to establish a new certificate of birth in the names of the intended parents.

5. Upon request of a person and in accordance with requirements of the Board, the State Registrar shall issue a new certificate of birth to show a change of sex of the person and, if a certified copy of a court order changing the person's name is submitted, to show a new name. Requirements related to obtaining a new certificate of birth to show a change of sex shall include a requirement that the person requesting the new certificate of birth submit a form furnished by the State Registrar and completed by a health care provider from whom the person has received treatment stating that the person has undergone clinically appropriate treatment for gender transition. Requirements related to obtaining a new certificate of birth to show a change of sex shall not include any requirement for evidence or documentation of any medical procedure.

6. Nothing in this section shall deprive the circuit court of equitable jurisdiction to adjudicate, upon application of a person, that the sex of such person residing within the territorial jurisdiction of the circuit court has been changed. In such an action, the person may petition for the application of the standard of the person's jurisdiction of birth; otherwise, the requirements of this section shall apply.

B. When a new certificate of birth is established pursuant to subsection A, the actual place and date of birth shall be shown. It shall be substituted for the original certificate of birth. Thereafter, the original certificate and the evidence of adoption, paternity or legitimation shall be sealed and filed and not be subject to inspection except upon order of a court of the Commonwealth or in accordance with § 32.1-252. However, upon receipt of notice of a decision or order granting an adult adopted person access to identifying information regarding his birth parents from the Commissioner of Social Services or a circuit court, and proof of identification and payment, the State Registrar shall mail an adult adopted person a copy of the original certificate of birth.

C. Upon receipt of a report of an amended decree of adoption, the certificate of birth shall be amended as provided by regulation.

D. Upon receipt of notice or decree of annulment of adoption, the original certificate of birth shall be restored to its place in the files and the new certificate and evidence shall not be subject to inspection except upon order of a court of the Commonwealth or in accordance with § 32.1-252.

E. The State Registrar shall, upon request, establish and register a Virginia certificate of birth for a person born in a foreign country (i) upon receipt of a report of adoption for an adoption finalized pursuant to the laws of the foreign country as provided in subsection B of § 63.2-1200.1, or (ii) upon receipt of a report or final order of adoption entered in a court of the Commonwealth as provided in § 32.1-262; however, a Virginia certificate of birth shall not be established or registered if so requested by the

court decreeing the adoption, the adoptive parents or the adopted person if 18 years of age or older. If a circuit court of the Commonwealth corrects or establishes a date of birth for a person born in a foreign country during the adoption proceedings or upon a petition to amend a certificate of foreign birth, the State Registrar shall issue a certificate showing the date of birth established by the court. After registration of the birth certificate in the new name of the adopted person, the State Registrar shall seal and file the report of adoption which shall not be subject to inspection except upon order of a court of the Commonwealth or in accordance with § 32.1-252. The birth certificate shall (i) show the true or probable foreign country of birth and (ii) state that the certificate is not evidence of United States citizenship for the child for whom it is issued or for the adoptive parents. However, for any adopted person who has attained United States citizenship, the State Registrar shall, upon request and receipt of evidence demonstrating such citizenship, establish and register a new certificate of birth that does not contain the statement required by clause (ii).

F. If no certificate of birth is on file for the person for whom a new certificate is to be established under this section, a delayed certificate of birth shall be filed with the State Registrar as provided in § 32.1-259 or 32.1-260 before a new certificate of birth is established, except that when the date and place of birth and parentage have been established in the adoption proceedings, a delayed certificate shall not be required.

G. When a new certificate of birth is established pursuant to subdivision A 1, the State Registrar shall issue along with the new certificate of birth a document, furnished by the Department of Social Services pursuant to § 63.2-1220, listing all post-adoption services available to adoptive families.

Code 1950, § 32-353.19; 1956, c. 259; 1960, c. 451; 1972, c. 823; 1977, c. 531; 1979, c. 711; 1983, c. 240; 1984, c. 219; 1991, c. 600; 2003, c. 985; 2011, cc. 486, 784; 2014, c. 621; 2015, cc. 5, 17; 2020, cc. 465, 466.

§ 32.1-261.1. Repealed.

Repealed by Acts 1991, c. 95.

Article 3 - RECORDS OF ADOPTIONS

§ 32.1-262. Records of adoptions.

A. For each adoption decreed by a court in this Commonwealth, the court shall require the preparation of a report of adoption on a form furnished by the State Registrar. The report shall (i) include such facts as are necessary to locate and identify the original certificate of birth of the person adopted or, in the case of a person who was born in a foreign country, evidence from sources determined to be reliable by the court as to the date, place of birth and parentage of such person; (ii) provide information necessary to establish a new certificate of birth of the person adopted; and (iii) identify the order of adoption and be certified by the clerk of court.

B. Information in the possession of the petitioner necessary to prepare the report of adoption shall be furnished with the petition for adoption by each petitioner for adoption or by his attorney. In all cases where a child is placed for adoption by a child-placing agency, the report shall be completed and filed

with the court by a representative of the agency. A final order of adoption shall not be entered until the information required by this section has been furnished unless the court, for good cause shown, finds the information to be unavailable or unnecessary.

C. On or before the tenth day of each month, the clerk of such court shall forward to the State Registrar all records of decrees of adoption entered in the preceding calendar month, together with such related reports as the State Registrar may require.

D. When the State Registrar receives a report of adoption, annulment of adoption, amendment, or amendment of a decree of adoption for a person born outside this Commonwealth, such report shall be forwarded to the appropriate registration authority in the state of birth. When the State Registrar receives a report of adoption from a court in this Commonwealth for a person born in a foreign country, a birth certificate shall be registered for such person in accordance with the provisions of § 32.1-261, and a copy of the report of adoption shall be transmitted to the appropriate federal agency.

Code 1950, § 32-353.32; 1964, c. 99; 1977, cc. 135, 531; 1979, c. 711; 1983, c. 240; 1988, c. 431; 2003, c. 504; 2004, c. 88.

Article 4 - Death Certificates and Out-of-State Transit Permits

§ 32.1-263. Filing death certificates; medical certification; investigation by Office of the Chief Medical Examiner.

A. A death certificate, including, if known, the social security number or control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 of the deceased, shall be filed for each death that occurs in the Commonwealth. Non-electronically filed death certificates shall be filed with the registrar of any district in the Commonwealth within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Electronically filed death certificates shall be filed with the State Registrar of Vital Records through the Electronic Death Registration System within three days after such death and prior to final disposition or removal of the body from the Commonwealth. Any death certificate shall be registered by such registrar if it has been completed and filed in accordance with the following requirements:

1. If the place of death is unknown, but the dead body is found in the Commonwealth, the death shall be registered in the Commonwealth and the place where the dead body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by approximation, taking into consideration all relevant information, including information provided by the immediate family regarding the date and time that the deceased was last seen alive, if the individual died in his home; and

2. When death occurs in a moving conveyance, in the United States of America and the body is first removed from the conveyance in the Commonwealth, the death shall be registered in the Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in the Commonwealth, the death

shall be registered in the Commonwealth but the certificate shall show the actual place of death insofar as can be determined.

B. The licensed funeral director, funeral service licensee, office of the state anatomical program, or next of kin as defined in § 54.1-2800 who first assumes custody of a dead body shall complete the certificate of death. He shall obtain personal data of the deceased necessary to complete the certificate of death, including the social security number of the deceased or control number issued to the deceased by the Department of Motor Vehicles pursuant to § 46.2-342, from the best qualified person or source available and obtain the medical certification from the person responsible therefor.

If a licensed funeral director, funeral service licensee, or representative of the office of the state anatomical program completes the certificate of death, he shall file the certificate of death with the State Registrar of Vital Records electronically using the Electronic Death Registration System and in accordance with the requirements of subsection A. If a member of the next of kin of the deceased completes the certificate of death, he shall file the certificate of death in accordance with the requirements of subsection A but shall not be required to file the certificate of death electronically.

C. The medical certification shall be completed and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System within 24 hours after death by the physician or autonomous nurse practitioner in charge of the patient's care for the illness or condition that resulted in death except when inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, or by the physician or autonomous nurse practitioner who pronounces death pursuant to § 54.1-2972. If the death occurred while under the care of a hospice provider, the medical certification shall be completed by the decedent's health care provider and filed electronically with the State Registrar of Vital Records using the Electronic Death Registration System for completion of the death certificate.

In the absence of such physician or autonomous nurse practitioner or with his approval, the certificate may be completed and filed by the following: (i) another physician or autonomous nurse practitioner employed or engaged by the same professional practice; (ii) a physician assistant supervised by such physician; (iii) an advanced practice registered nurse who is not an autonomous nurse practitioner practicing in accordance with the provisions of § 54.1-2957; (iv) the chief medical officer or medical director, or his designee, of the institution, hospice, or nursing home in which death occurred; (v) a physician or autonomous nurse practitioner specializing in the delivery of health care to hospitalized or emergency department patients who is employed by or engaged by the facility where the death occurred; (vi) the physician who performed an autopsy upon the decedent; (vii) an individual to whom the physician or autonomous nurse practitioner has delegated authority to complete and file the certificate, if such individual has access to the medical history of the case and death is due to natural causes; or (viii) a physician who is not licensed by the Board of Medicine who was in charge of the patient's care for the illness or condition that resulted in death. A physician described in clause (viii) who completes a certificate in accordance with this subsection shall not be required to register with the Electronic Death Registration System or complete the certificate electronically.

As used in this subsection, "autonomous nurse practitioner" has the same meaning as provided in § 54.1-2972.

D. When inquiry or investigation by the Office of the Chief Medical Examiner is required by § 32.1-283 or 32.1-285.1, the Chief Medical Examiner shall cause an investigation of the cause of death to be made and the medical certification portion of the death certificate to be completed and filed within 24 hours after being notified of the death. If the Office of the Chief Medical Examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and file the medical certification portion of the death certificate.

E. If the death is a natural death and a death certificate is being prepared pursuant to § 54.1-2972 and the physician, autonomous nurse practitioner, or physician assistant is uncertain about the cause of death, he shall use his best medical judgment to certify a reasonable cause of death or contact the health district physician director in the district where the death occurred to obtain guidance in reaching a determination as to a cause of death and document the same.

If the cause of death cannot be determined within 24 hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or autonomous nurse practitioner, as defined in § 54.1-2972, or the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician, autonomous nurse practitioner, the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

F. A physician, autonomous nurse practitioner, physician assistant, or individual delegated authority to complete and file a certificate of death by a physician who, in good faith, files a certificate of death or determines the cause of death shall be immune from civil liability, only for such filing and determination of causes of death on such certificate, absent gross negligence or willful misconduct.

Code 1950, § 32-353.20; 1960, c. 451; 1978, c. 308; 1979, c. 711; 1983, c. 240; 1993, c. 965; 1997, cc. 794, 898; 2003, c. 484; 2004, c. 124; 2008, c. 137; 2011, c. 613; 2012, c. 213; 2013, c. 799; 2014, c. 583; 2017, c. 784; 2018, cc. 207, 208, 776; 2019, cc. 213, 224; 2022, c. 184; 2023, c. 183.

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by the Office of the Chief Medical Examiner; confidentiality of information concerning abortions.

A. A fetal death report for each fetal death which occurs in this Commonwealth shall be filed, on a form furnished by the State Registrar, with the registrar of the district in which the delivery occurred or the abortion was performed within three days after such delivery or abortion and shall be registered with such registrar if it has been completed and filed in accordance with this section, provided that:

1. If the place of fetal death is unknown, a fetal death report shall be filed in the registration district in which a dead fetus was found within three days after discovery of such fetus; and

2. If a fetal death occurs in a moving conveyance, a fetal death report shall be filed in the registration district in which the fetus was first removed from such conveyance.

B. The funeral director or person who first assumes custody of a dead fetus or, in the absence of a funeral director or such person, the hospital representative who first assumes custody of a fetus shall file the fetal death report; in the absence of such a person, the physician or other person in attendance at or after the delivery or abortion shall file the report of fetal death. The person completing the forms shall obtain the personal data from the next of kin or the best qualified person or source available, and he shall obtain the medical certification of cause of death from the person responsible for preparing the same as provided in this section. In the case of induced abortion, such forms shall not identify the patient by name.

C. The medical certification portion of the fetal death report shall be completed and signed within 24 hours after delivery or abortion by the physician in attendance at or after delivery or abortion except when inquiry or investigation by the Office of the Chief Medical Examiner is required.

D. When a fetal death occurs without medical attendance upon the mother at or after the delivery or abortion or when inquiry or investigation by the Office of the Chief Medical Examiner is required, the Chief Medical Examiner shall cause an investigation of the cause of fetal death to be made and the medical certification portion of the fetal death report to be completed and signed within 24 hours after being notified of a fetal death.

E. The reports required pursuant to this section are statistical reports to be used only for medical and health purposes and shall not be incorporated into the permanent official records of the system of vital records. A schedule for the disposition of these reports may be provided by regulation.

F. The physician or facility attending an individual who has delivered a dead fetus shall maintain a copy of the fetal death report for one year and, upon written request by the individual and payment of an appropriate fee, shall furnish the individual a copy of such report.

Code 1950, § 32-353.21; 1960, c. 451; 1975, c. 267; 1979, c. 711; 1983, c. 240; 1987, c. 405; 2014, c. 583.

§ 32.1-265. Transit permits; permits for disinterment and reinterment.

A. The funeral director or other person who first assumes custody of a dead body or fetus shall obtain an out-of-state transit permit prior to removal from the Commonwealth of the body or fetus.

B. Such out-of-state transit permit shall be issued by the registrar of the district where a satisfactorily completed certificate of death or fetal death was filed.

C. A transit permit issued under the law of another state which accompanies a dead body or fetus brought into this Commonwealth shall be authority for final disposition of the body or fetus in this Commonwealth.

D. No permit shall be required where disposal of dead bodies or fetuses for deaths or fetal deaths which have occurred in this Commonwealth is to be made in this Commonwealth.

E. A permit for disinterment and reinterment shall be required prior to disinterment of a dead body or fetus except as authorized by regulation of the Board or otherwise provided by law. Such permit shall be issued by the State Registrar or the registrar of the county or city where the body or fetus is interred to a licensed funeral director.

Code 1950, § 32-353.22; 1960, c. 451; 1970, c. 699; 1979, c. 711.

§ 32.1-266. Extending time for filing death certificates and obtaining out-of-state transit permits.
The Board may provide by regulation for the extension, upon conditions designed to assure compliance with the purposes of this chapter, of the periods prescribed in §§ 32.1-263, 32.1-264 and 32.1-265 for the filing of death certificates, fetal death reports and medical certifications of cause of death and for the obtaining of out-of-state transit permits in cases in which compliance with the applicable prescribed period would result in undue hardship.

Code 1950, § 32-353.23; 1960, c. 451; 1979, c. 711.

Article 5 - Marriage Records and Divorce and Annulment Reports

§ 32.1-267. Records of marriages; duties of officer issuing marriage license and person officiating at ceremony; blocking of social security number.
A. For each marriage performed in the Commonwealth, a record showing personal data, including the age of the married parties, the marriage license, and the certifying statement of the facts of marriage, shall be filed with the State Registrar as provided in this section.

B. The officer issuing a marriage license shall prepare the record based on the information obtained under oath or by affidavit from the parties to be married. The parties shall also include their social security numbers or other control numbers issued by the Department of Motor Vehicles pursuant to § 46.2-342 and affix their signatures to the application for such license.

C. Every person who officiates at a marriage ceremony shall certify to the facts of marriage and file the record in duplicate with the officer who issued the marriage license within five days after the ceremony. In the event such officiant dies or becomes incapacitated before completing the certificate of marriage, the official who issued the marriage license shall complete the certificate of marriage upon the order of the court to which is submitted proof that the marriage was performed.

D. Every officer issuing marriage licenses shall on or before the tenth day of each calendar month forward to the State Registrar a record of each marriage filed with him during the preceding calendar month.

E. The State Registrar shall furnish forms for the marriage license, marriage certificate, and application for marriage license used in the Commonwealth. Such forms shall be configured so as to cause the social security number or control number required pursuant to the provisions of subsection B to appear only on the application for marriage license retained by the officer issuing the marriage license and the copy of such license forwarded to the State Registrar pursuant to the provisions of subsection D.

F. Applications for marriage licenses filed on and after July 1, 1997, and marriage registers recording such applications, which have not been configured to prevent disclosure of the social security number or control number required pursuant to the provisions of subsection B shall not be available for general public inspection in the offices of clerks of the circuit courts. The clerk shall make such applications and registers available for inspection only (i) upon the order of the circuit court within which such application was made or register is maintained, (ii) pursuant to a lawful subpoena duces tecum issued to the clerk, (iii) upon the written authorization of either of the applicants, or (iv) upon the request of a law-enforcement officer or duly authorized representative of the Division of Child Support Enforcement in the course of performing his official duties. Nothing in this subsection shall be construed to restrict public access to marriage licenses or to prohibit the clerk from making available to the public applications for marriage licenses and marriage registers stored in any electronic medium or other format that permits the blocking of the field containing the social security or control number required pursuant to the provisions of subsection B, so long as access to such number is blocked.

Code 1950, § 32-353.34; 1968, c. 318; 1972, c. 92; 1979, c. 711; 1997, cc. 794, 898; 2001, c. 836; 2002, c. 832; 2003, c. 504; 2004, c. 88; 2005, c. 679; 2020, cc. 209, 210, 211.

§ 32.1-268. Reports of divorces and annulments.

A. For each final decree of divorce or annulment of marriage granted by a court in the Commonwealth, a report shall be certified and filed by the clerk of court with the State Registrar. The information necessary to prepare the report, including the social security number of each party or the control number issued a party by the Department of Motor Vehicles pursuant to § 46.2-342, shall be furnished, with the petition or when filing the decree, to the clerk of the court by the petitioner or his attorney on forms prescribed by the Board and furnished by the State Registrar. Information on the report shall include the age of the parties and the number of minor children involved in the divorce or annulment.

B. On or before the tenth day of each month the clerk of court shall forward to the State Registrar the report of each final decree of divorce and annulment granted during the preceding calendar month and such related reports as the State Registrar may require.

Code 1950, § 32-353.33; 1964, c. 99; 1972, c. 312; 1977, c. 135; 1979, c. 711; 1997, cc. 794, 898; 2002, c. 353; 2004, c. 88; 2005, c. 679; 2020, cc. 209, 210, 211.

§ 32.1-268.1. Compilation and posting of marriage, divorce, and annulment data.

The State Registrar shall compile, publish, and make available to the public aggregate data on the number of marriages, divorces, and annulments from the year 2000 forward that occurred in the Commonwealth. The data shall be organized according to the locality in which the marriage license is issued or in which the divorce or annulment report is certified and shall include the age of the parties. In addition, the data on divorces and annulments shall include information regarding the number of minor children involved. The State Registrar shall post, update, and maintain this information on the Department website. Names, addresses, social security numbers, and any other personal identification information shall not be included.

2005, c. 679; 2020, cc. 209, 210, 211.

Article 6 - Amendments to Vital Records

§ 32.1-269. Amending vital records; change of name; acknowledgment of paternity.

A. A vital record registered under this chapter, with the exception of a death certificate, may be amended only in accordance with this section and such regulations as may be adopted by the Board to protect the integrity and accuracy of such vital records. Such regulations shall specify the minimum evidence required for a change in any such vital record.

B. Except in the case of an amendment provided for in subsection D, a vital record that is amended under this section shall be marked "amended" and the date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the vital record. The Board shall prescribe by regulation the conditions under which omissions or errors on certificates, including designation of sex, may be corrected within one year after the date of the event without the certificate being marked amended. In a case of hermaphroditism or pseudo-hermaphroditism, the certificate of birth may be corrected at any time without being considered as amended upon presentation to the State Registrar of such medical evidence as the Board may require by regulation.

C. Every request for an amendment to a birth certificate shall be reviewed to determine whether the requested amendment can be made administratively in accordance with regulations of the Board or if a judicial order is required for such amendment. The Department shall make information about the process by which amendments to a birth certificate may be requested and reviewed pursuant to this subsection available to the public on its website. Such information shall include a standard form for requests for amendments to a birth certificate.

D. Upon receipt of a certified copy of a court order changing the name of a person as listed in a vital record and upon request of such person or his parent, guardian, or legal representative or the registrant, the State Registrar shall amend such vital records to reflect the new name.

E. Upon written request of both parents and receipt of a sworn acknowledgment of paternity executed subsequent to the birth and signed by both parents of a child born out of wedlock, the State Registrar shall amend the certificate of birth to show such paternity if paternity is not shown on the birth certificate. Upon request of the parents, the surname of the child shall be changed on the certificate to that of the father.

F. When an applicant does not submit the minimum documentation required by regulation to amend a vital record, the State Registrar finds reason to question the validity or sufficiency of the evidence, or the requested amendment requires a judicial order, the vital record shall not be amended and the State Registrar shall so notify the applicant in writing. Such notification shall also include notice to the applicant regarding his right to petition the court for an order in accordance with subsection G.

G. Any person aggrieved by the decision of the State Registrar to deny a request to amend a vital record may petition the circuit court of the county or city in which he resides or the Circuit Court of the City of Richmond, Division I, for an order compelling the State Registrar to amend the vital record; an

aggrieved applicant who was born in Virginia, but is currently residing out of State, may petition any circuit court in the Commonwealth for such an order. The State Registrar or his authorized representative may appear and testify in such proceeding.

Code 1950, § 32-353.24; 1956, c. 259; 1960, c. 451; 1979, c. 711; 1983, c. 240; 1985, c. 86; 2016, c. 496; 2020, cc. 465, 466; 2021, Sp. Sess. I, c. 237.

§ 32.1-269.1. Amending death certificates; change and correction of demographic information by affidavit or court order.

A. Notwithstanding § 32.1-276, a death certificate registered under this chapter may be amended only in accordance with this section and such regulations as may be adopted by the Board to protect the integrity and accuracy of such death certificate. Such regulations shall specify the minimum evidence required for a change in any such death certificate.

B. A death certificate that is amended under this section shall be marked "amended," and the date of amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the death certificate. The Board shall prescribe by regulation the conditions under which omissions or errors on death certificates may be corrected.

C. The State Registrar, upon receipt of an affidavit and supporting evidence testifying to corrected information on a death certificate within 45 days of the filing of a death certificate, shall amend such death certificate to reflect the new information and evidence.

D. The State Registrar, upon receipt of an affidavit and supporting evidence testifying to corrected information on a death certificate more than 45 days after the filing of a death certificate, including the correct spelling of the name of the deceased, the deceased's parent or spouse, or the informant; the sex, age, race, date of birth, place of birth, citizenship, social security number, education, occupation or kind or type of business, military status, or date of death of the deceased; the place of residence of the deceased, if located within the Commonwealth; the name of the institution; the county, city, or town where the death occurred; or the street or place where the death occurred, shall amend such death certificate to reflect the new information and evidence.

E. For death certificate amendments received more than 45 days after the filing of a death certificate, other than the correction of information by the State Registrar pursuant to subsection D, the surviving spouse or immediate family, as defined by the regulations of the Board, of the deceased; attending funeral service licensee; or other reporting source may file a petition with the circuit court of the county or city in which the decedent resided as of the date of his death, or the Circuit Court of the City of Richmond, requesting an order to amend a death certificate, along with an affidavit sworn to under oath that supports such request. A copy of the petition shall be served upon (i) the State Registrar pursuant to Chapter 8 (§ 8.01-285 et seq.) of Title 8.01 and (ii) any person listed as an informant on the death certificate, unless such person provides an affidavit in support of such petition. The clerk shall submit such petition and any evidence received with the petition to the judge for entry of an order without the necessity of a hearing, unless the judge decides a hearing is necessary. The clerk shall transmit a

certified copy of the court's order to the State Registrar, who shall amend such death certificate in accordance with the order. The matters for which a petition may be filed include changing the name of the deceased, the deceased's parent or spouse, or the informant; the marital status of the deceased; or the place of residence of the deceased, when the place of residence is outside the Commonwealth.

F. When an applicant, as defined by the regulations of the Board, does not submit the minimum documentation required by regulation to amend a death certificate or when the State Registrar finds reason to question the validity or sufficiency of the evidence, the death certificate shall not be amended and the State Registrar shall so advise the applicant. An aggrieved applicant may petition the circuit court of the county or city in which he resides, or the Circuit Court of the City of Richmond, for an order compelling the State Registrar to amend the death certificate; an aggrieved applicant who is currently residing out of state may petition any circuit court in the Commonwealth for such an order. A copy of the petition shall be served upon (i) the State Registrar pursuant to Chapter 8 (§ 8.01-285 et seq.) of Title 8.01 and (ii) any person listed as an informant on the death certificate, unless such person provides an affidavit in support of such petition. The clerk shall submit such petition and any evidence received with the petition to the judge for entry of an order without the necessity of a hearing, unless the judge decides a hearing is necessary. The State Registrar or his authorized representative may appear and testify in such proceeding. The clerk shall transmit a certified copy of the court's order to the State Registrar, who shall amend such death certificate in accordance with the order.

2016, c. 496; 2017, cc. 284, 285; 2022, cc. 116, 117.

Article 7 - MISCELLANEOUS PROVISIONS

§ 32.1-270. State Registrar may reproduce records; disposition of documents from which permanent reproductions made.

To preserve original documents, the State Registrar is authorized to prepare typewritten, photographic, electronic, or other reproductions of original vital records in his custody. Such reproductions when certified by him shall be accepted as the original records.

The documents from which permanent reproductions have been made and verified may be disposed of as provided by regulation.

Any vital record issued by the Department of Motor Vehicles shall be on security paper provided by the State Registrar and shall be considered a certified vital record and accepted as the original record.

Code 1950, § 32-353.25; 1960, c. 451; 1979, c. 711; 1983, c. 240; 2013, c. 534.

§ 32.1-271. Disclosure of information in records; when unlawful; when permitted; proceeding to compel disclosure; when certain records made public.

A. To protect the integrity of vital records and to ensure the efficient and proper administration of the system of vital records, it is unlawful, notwithstanding the provisions of §§ 2.2-3700 through 2.2-3714, for any person to permit inspection of or to disclose information contained in vital records or to copy or

issue a copy of all or part of any such vital records except as authorized by this section or regulation of the Board or when so ordered by a court of the Commonwealth.

B. Data contained in vital records may be disclosed for valid and substantial research purposes in accordance with the regulations of the Board.

C. Any person aggrieved by a decision of a county or city registrar may appeal to the State Registrar. If the State Registrar denies disclosure of information or inspection of or copying of vital records, such person may petition the court of the county or city in which he resides if he resides in the Commonwealth or in which the recorded event occurred or the Circuit Court of the City of Richmond, Division I, for an order compelling disclosure, inspection or copying of such vital record. The State Registrar or his authorized representative may appear and testify in such proceeding.

D. When 100 years have elapsed after the date of birth, or 25 years have elapsed after the date of death, marriage, divorce, or annulment the records of these events in the custody of the State Registrar shall, unless precluded from release by statute or court order, or at law-enforcement request, become public information and be made available in accordance with regulations that shall provide for the continued safekeeping of the records. All records that are public information on July 1, 1983, shall continue to be public information. Original records in the custody of the State Registrar that become public information shall be turned over to the Library of Virginia for safekeeping and for public access consistent with other state archival records, subject to the State Registrar and the Library of Virginia entering into a memorandum of understanding to arrange for continued prompt access by the State Registrar to original records for purposes of amendments to those records or other working purposes. The State Registrar's office may retain copies thereof for its own administrative and disclosure purposes.

E. The State Registrar or the city or county registrar shall disclose data about or issue a certified copy of a birth certificate of a child to the grandparent of the child upon the written request of the grandparent when the grandparent has demonstrated to the State Registrar evidence of need, as prescribed by Board regulation, for the data or birth certificate.

F. The State Registrar or the city or county registrar shall issue a certified copy of a death certificate to the grandchild or great-grandchild of a decedent in accordance with procedures prescribed by the Board in regulation.

G. The State Registrar or the city or county registrar shall disclose data about or issue a certified copy of a death certificate to a nonprofit organ, eye or tissue procurement organization that is a member of the Virginia Transplant Council for the purpose of determining the suitability of organs, eyes and tissues for donation, as prescribed by the Board in regulations. Such regulations shall ensure that the information disclosed includes the cause of death and any other medical information necessary to determine the suitability of the organs, eyes, and tissues for donation.

H. The State Registrar shall seek to enter into a long-term contract with a private company experienced in maintaining genealogical research databases to create, maintain, and update such an

online index at no direct cost to the Commonwealth, in exchange for allowing the private company to also provide such index to its subscribers and customers. The online index shall be designed and constructed to have the capability of allowing birth, marriage, divorce, and death entries on the index to be linked to a digital image of the underlying original birth, marriage, divorce, or death record once any such underlying record has become public information, and the index shall be designed to allow the Library of Virginia to create and activate such links to digital images of the original records. Any social security numbers appearing on original birth, marriage, divorce, or death records shall be redacted from the digital images provided to the public in the manner provided by law, which may include bulk redaction of social security fields from the images via automated methods.

Following contract implementation, the State Registrar shall maintain a publicly available online vital records index or indexes, consisting at a minimum of name, date, and county or city of occurrence for births (naming the child), marriages (naming the spouses), divorces (naming the parties to the divorce), and deaths (naming the decedent), which vital records index information, except as otherwise precluded from release by statute, court order, or law-enforcement request, shall be public information from the time of its receipt by the State Registrar and shall be accessible on the State Registrar's website and on or through the Library of Virginia website.

Code 1950, § 32-353.26; 1960, c. 451; 1979, c. 711; 1983, c. 240; 1984, c. 189; 1985, c. 313; 2005, c. 60; 2009, c. 505; 2011, c. 109; 2012, cc. 16, 356; 2020, c. 900.

§ 32.1-272. Certified copies of vital records; other copies.

A. In accordance with § 32.1-271 and the regulations adopted pursuant thereto, the State Registrar or a district health department shall, upon receipt of a written request, issue a certified copy of any vital record in the custody of the State Registrar or of a part thereof.

The Commissioner of the Department of Motor Vehicles shall be authorized to issue a certified copy of a birth, death, marriage, or divorce vital record, or a part thereof, in the custody of the State Registrar.

Such vital records in the State Registrar's custody may be in the form of originals, photoprocessed reproductions or data filed by electronic means.

Each copy issued shall show the date of registration. Any copy issued from a record marked "delayed" or "amended," except a record amended pursuant to subsection F of this section or subsection E of § 32.1-269, shall be similarly marked and show the effective date.

Certified copies may be issued by county and city registrars only while the original record is in their possession, except that at the option of the county or city registrar true and complete copies of death certificates may be retained and certified copies of such records may be issued by the county or city registrar.

B. A certified copy of a vital record or any part thereof issued in accordance with subsection A shall be considered for all purposes the same as the original and shall be prima facie evidence of the facts therein stated, provided that the evidentiary value of a vital record filed more than one year after the

event or a vital record which has been amended shall be determined by the judicial or administrative body or official before whom the certificate is offered as evidence.

C. The federal agency responsible for national vital statistics may be furnished such copies or other data from the system of vital records as it may require for national statistics if such federal agency shares in the cost of collecting, processing and transmitting such data. Such data may be used for research and medical investigations of public health importance. No other use of such data shall be made by the federal agency unless authorized by the State Registrar.

D. Other federal, state and local, public or private agencies or persons in the conduct of their official duties may, upon request and payment of a reasonable fee, be furnished copies or other data from the system of vital records for statistical or administrative purposes upon such terms or conditions as may be prescribed by the Board. Such copies or other data shall not be used for purposes other than those for which they were requested unless so authorized by the State Registrar.

In promulgating regulations relating to the terms or conditions for public or private agencies or persons obtaining copies of death certificates in the conduct of their official duties, the Board shall include within its definition of "legal representative" (i) any attorney licensed to practice law in Virginia, upon presentation of his bar number and evidence of need to obtain such copy; and (ii) any funeral director or funeral service licensee licensed to practice by the Board of Funeral Directors and Embalmers, upon presentation of evidence to so practice and evidence of being in charge of final disposition of the registrant's dead human remains or cremains or evidence of need to obtain such copy.

E. No person shall prepare or issue any certificate which purports to be an original or certified copy of a vital record except as authorized in this chapter or regulations adopted hereunder.

F. Certified copies of birth records filed before July 1, 1960, containing statements of racial designation on the reverse thereof shall be issued without such statement as a part of the certification; nor for this purpose solely shall such certification be marked "amended."

Any American Indian or Native American whose certified copy of a birth record filed before July 1, 1960, contains a racial designation that is incorrect may obtain, without paying a fee, one certified copy of his birth record from which such incorrect racial designation has been removed. Such certification shall not be marked "amended" solely for this reason.

G. With the increased fees to be charged for vital records and the additional deposits to the Vital Statistics Automation Fund, the Board of Health shall establish, within the district health departments, a statewide system for decentralizing certification of vital records, when such records are prepared or issued from data in the custody of the State Registrar and the Board of Health. Such system shall include the Department of Motor Vehicles pursuant to the authorization in subsection A.

Code 1950, § 32-353.27; 1950, pp. 484, 485; 1954, c. 429; 1956, c. 412; 1958, c. 296; 1960, c. 451; 1966, c. 353; 1972, c. 500; 1979, c. 711; 1983, c. 240; 1994, c. 373; 1997, c. 470; 1999, c. 600; 2005, c. 448; 2013, c. 534; 2021, Sp. Sess. I, c. 237.

§ 32.1-273. Fees for certified copies, searches of files, etc.; disposition.

A. The Board shall prescribe the fee, not to exceed $12, for a certified copy of a vital record or for a search of the files or records when no copy is made and may establish a reasonable fee schedule related to its cost for information or other data provided for research, statistical or administrative purposes. Whenever any veteran or his survivor requires a certified copy of a vital record to obtain service-connected benefits, one copy of such record shall be provided directly to the U.S. Department of Veterans Affairs upon their request and one copy shall be provided to the veteran or his surviving spouse, upon request. Upon request of the surviving spouse of a veteran, the funeral director or funeral service licensee providing funeral services for the veteran may obtain one certified copy of the death certificate for service-connected benefits. No charge shall be imposed upon a veteran or his survivor for a copy related to obtaining service-connected benefits.

B. Fees collected under this section by the State Registrar shall be transmitted to the Comptroller for deposit. Two dollars of each fee collected by the State Registrar shall be deposited by the Comptroller into the Vital Statistics Automation Fund established pursuant to § 32.1-273.1 for so long as shall be authorized. Ten dollars of each fee shall be credited to a special fund to be appropriated by the General Assembly, as it deems necessary, for the purpose of carrying out the provisions of this chapter. When the Vital Statistics Automation System is completed, no further deposits into the fund shall be made and all fees collected under this section not credited to the special fund created by this subsection shall be deposited into the general fund of the state treasury.

C. The Department of Motor Vehicles shall collect a fee of $12 for each certified copy of a vital record that it issues and shall transmit all such fees to the State Registrar on a monthly basis to ensure that the State Registrar recovers all costs associated with the issuance of certified copies of vital records at Department of Motor Vehicles facilities. In addition, for each certified copy of a vital record that it issues, the Department of Motor Vehicles shall collect a processing fee of $2 as provided in § 46.2-205.2.

D. Fees collected under this section by county and city registrars shall be deposited in the general fund of the county or city except that counties or cities operating health departments pursuant to the provisions of § 32.1-31 shall forward all such fees to the Department for deposit in the cooperative local health services fund.

E. Fees assessed against local departments of social services for furnished copies of vital records as needed to administer public assistance and social services programs, as defined in § 63.2-100, shall be payable on a quarterly basis.

Code 1950, § 32-353.28; 1950, p. 484; 1954, c. 429; 1956, c. 412; 1958, c. 296; 1960, c. 451; 1978, c. 308; 1979, c. 711; 1981, c. 527; 1983, c. 240; 1986, c. 194; 1988, c. 287; 1994, c. 373; 2002, c. 747; 2011, cc. 94, 148; 2013, c. 534; 2020, c. 360.

§ 32.1-273.1. Virginia Vital Statistics Automation Fund.

For the purpose of fully automating the system of vital records provided for in this chapter, including the statewide system for decentralizing certification of vital records, there is hereby established the Virginia Vital Statistics Automation Fund.

Four dollars of each fee collected by the State Registrar shall be deposited by the Comptroller to this fund to be appropriated for this purpose to the Department of Health by the General Assembly as it deems necessary.

Deposits to this fund shall cease at such time as the system of vital records for Virginia has become fully automated and the fund shall expire. Any funds unexpended at expiration shall revert to the general fund.

1983, c. 235; 1994, c. 373.

§ 32.1-274. Persons in charge of institutions and funeral directors, etc., to keep records; lists sent to State Registrar.

A. Every person in charge of an institution shall keep a record of personal data concerning each person admitted or confined to such institution. This record shall include such information as required for the certificates of birth, death, and reports of spontaneous fetal death and induced termination of pregnancy required by this chapter. The record shall be made at the time of admission from information provided by the person being admitted or confined, but when it cannot be so obtained, the information shall be obtained from relatives or other persons acquainted with the facts. The name and address of the person providing the information shall be a part of the record.

B. When a dead human body is released or disposed of by an institution, the person in charge of the institution shall keep a record showing the name of the deceased, date of death, the name and address of the person to whom the body is released and the date of removal from the institution, or, if final disposal is by the institution, the date, place, and manner of disposition.

C. A funeral director, embalmer, or other person who removes from the place of death or transports or is in charge of final disposition of a dead body or fetus, in addition to filing any certificate, report or form required by this chapter, shall keep a record which shall identify the body, and such information pertaining to his receipt, removal, and delivery of such body as may be prescribed in regulations adopted by the Board.

D. Not later than the tenth day of the month following the month of occurrence, the administrator of each institution shall cause to be sent to the State Registrar a list showing thereon all births, deaths, and fetal deaths occurring in such institution during the preceding month. Such lists shall be on forms provided by the State Registrar.

E. Not later than the tenth day of the month following the month of occurrence, each funeral director shall send to the State Registrar a list showing thereon all caskets furnished, bodies prepared for disposition and transportation and funerals performed where no casket was furnished by the funeral director during the preceding month. Such lists shall be on forms provided by the State Registrar.

F. Records maintained under this section shall be retained for a period of not less than ten years and shall be made available for inspection by the State Registrar or his representative upon demand.

Code 1950, § 32-353.29; 1960, c. 451; 1979, c. 711; 1983, c. 240.

§ 32.1-275. Information as to births, deaths, marriages and divorces to be furnished on demand.

It shall be the duty of any person to furnish such information as he may possess regarding any birth, death, fetal death, marriage or divorce, upon demand of the State Registrar in person, by mail, or through the county, city, or special registrar.

Code 1950, § 32-353.30; 1960, c. 451; 1979, c. 711.

§ 32.1-275.1. Matching of birth and death certificates; marking of certificates and copies.

To protect the integrity of vital records and prevent the fraudulent use of birth certificates of deceased persons, the State Registrar is hereby authorized to match birth and death certificates, in accordance with regulations promulgated by the Board, to prove beyond a reasonable doubt the fact of death, and to post the facts of death to the appropriate birth certificate. Copies issued from birth certificates marked deceased shall be similarly marked.

1983, c. 240.

§ 32.1-275.2. Notation on birth records of missing children.

Upon receiving a report of the disappearance of any child born in this Commonwealth, the State Registrar shall indicate in a clear and conspicuous manner in the child's birth record that the child has been reported as missing, including the title and location of the law-enforcement agency providing the report. Upon receiving a request for any birth records containing a report of the disappearance of any child, the State Registrar shall immediately notify the local law-enforcement agency which provided the missing child report to the State Registrar. The State Registrar shall transmit any relevant information concerning the applicant's identity, address, and other pertinent data immediately to the relevant local law-enforcement agency. The State Registrar shall retain the original written request until notified of the missing child's recovery or the child attains the age of eighteen. Upon notification that any missing child has been recovered, the State Registrar shall remove the report of the disappearance from the child's birth record.

1990, c. 295.

§ 32.1-276. Penalty imposed for violations.

Any person who commits any of the following acts is guilty of a Class 4 felony:

1. Who willfully and knowingly makes any false statement in a report, record, or certificate required to be filed under this chapter, or in an application for an amendment, certification or verification of any such report, record or certificate, or who willfully and knowingly supplies false information intending that such information be used in the preparation of any such report, record, or certificate, or amendment thereof; or

2. Who without lawful authority and with the intent to deceive, makes, counterfeits, alters, amends, or mutilates any report, record, or certificate required to be filed under this chapter or a certified copy of such report, record, or certificate; or

3. [Repealed.]

4. Who willfully and knowingly obtains, possesses, uses, sells, furnishes or attempts to obtain, possess, use, sell, or furnish to another, for any purpose of deception, any certificate, record or report required by this chapter or certified copy thereof made, counterfeited, altered, amended, or mutilated or which is false in whole or part or which relates to the birth of another person whether living or deceased without lawful authority; or

5. [Repealed.]

6. Who is an employee of the State Registrar, the Department of Health, or the Department of Motor Vehicles while engaged in activities pertaining to the operation of the system of vital records who, without lawful authority, willfully and knowingly furnishes or possesses any certificate, report, record, or certification thereof, with the knowledge or intention that it be used for the purposes of deception; or

7. Who, without lawful authority, possesses any certificate, record, or report required by this chapter or a copy or certification of such certificate, record, or report knowing same to have been stolen or otherwise unlawfully obtained.

Code 1950, § 32-353.31; 1960, c. 451; 1979, c. 711; 1983, c. 240; 2013, c. 534.

Chapter 7.1 - HEALTH STATISTICS

§ 32.1-276.1. Center for Health Statistics; duties of Director.

A. The Board shall provide a Center for Health Statistics to perform data program development, reporting, systems operations, analysis and consultation, for the Department of Health, for county and city departments of health and other public agencies having health-related duties.

B. The Director of the Center for Health Statistics, under the supervision of the Commissioner, shall:

1. Supervise the Center for Health Statistics.

2. Collect other health-related records and reports and prepare, tabulate, analyze, and publish vital statistics and other health statistical data of this Commonwealth and such other reports as may be required by the Commissioner or the Board.

1983, c. 240.

Chapter 7.2 - HEALTH CARE DATA REPORTING

§ 32.1-276.2. Health care data reporting; purpose.

The General Assembly finds that the establishment of effective health care data analysis and reporting initiatives is essential to improving the quality and efficiency of health care, fostering competition among health care providers, and increasing consumer choice with regard to health care services in

the Commonwealth, and that accurate and valuable health care data can best be identified by representatives of state government and the consumer, provider, insurance, and business communities. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health and the Bureau of Insurance, shall administer the health care data reporting initiatives established by this chapter.

1996, c. 902; 2010, c. 416; 2012, cc. 693, 709.

§ 32.1-276.3. Definitions.

As used in this chapter:

"Actual reimbursement amount" means reimbursement information included in the claims data submitted by data suppliers to the Virginia All-Payer Claims Database, whether such information is referred to in the claims data as "paid amounts," "allowed amounts," or another term having the same or similar meaning and whether in reference to the payer who paid the actual reimbursement amount or the provider who received the actual reimbursement amount.

"Board" means the Board of Health.

"Common data layout" means the national data collection standard adopted and maintained by the APCD Council.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Covered lives" means subscribers, policyholders, members, enrollees, or dependents, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"ERISA plan" means any self-funded employee welfare benefit plan governed by the requirements of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title; (ii) a mental or psychiatric hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (iii) a hospital operated by the Department of Behavioral Health and Developmental Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; or (vii) any person licensed to practice dentistry pursuant to Chapter 27 (§ 54.1-2700 et seq.) of Title 54.1 who is registered with the Board of

Dentistry as an oral and maxillofacial surgeon and certified by the Board of Dentistry to perform certain procedures pursuant to § 54.1-2709.1. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5, a hospital licensed pursuant to Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2, a hospital operated by the Department of Behavioral Health and Developmental Services for the care and treatment of individuals with mental illness, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"Oral and maxillofacial surgeon" means, for the purposes of this chapter, a person who is licensed to practice dentistry in Virginia, registered with the Board of Dentistry as an oral and maxillofacial surgeon, and certified to perform certain procedures pursuant to § 54.1-2709.1.

"Oral and maxillofacial surgeon's office" means a place (i) owned or operated by a licensed and registered oral and maxillofacial surgeon who is certified to perform certain procedures pursuant to § 54.1-2709.1 or by a group of oral and maxillofacial surgeons, at least one of whom is so certified, practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages at least one oral and maxillofacial surgeon who is so certified, and (ii) designed and equipped for the provision of oral and maxillofacial surgery services to ambulatory patients.

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office or oral and maxillofacial surgeon's office, as defined above. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians and (ii) designed and equipped solely for the

provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

1996, cc. 902, 905, 1046; 1999, c. 764; 2000, cc. 720, 897; 2001, c. 341; 2003, c. 466; 2009, cc. 813, 840; 2019, cc. 672, 673.

§ 32.1-276.4. Agreements for certain data services.

A. The Commissioner shall negotiate and enter into contracts or agreements with a nonprofit organization for the compilation, storage, analysis, and evaluation of data submitted by health care providers pursuant to this chapter; for the operation of the All-Payer Claims Database pursuant to § 32.1-276.7:1; and for the development and administration of a methodology for the measurement and review of the efficiency and productivity of health care providers. Such nonprofit organization shall be governed by a board of directors composed of representatives of state government, including the Commissioner, representatives of the Department of Medical Assistance Services and the Bureau of Insurance, health plans and health insurance issuers, and the consumer, health care provider, and business communities. Of the health care provider representatives, there shall be an equal number of hospital, nursing home, physician, and health plan representatives. The articles of incorporation of such nonprofit organization shall require the nomination of such board members by organizations and associations representing those categories of persons specified for representation on the board of directors.

B. In addition to providing for the compilation, storage, analysis, and evaluation services described in subsection A, any contract or agreement with a nonprofit, tax-exempt health data organization made pursuant to this section shall require the board of directors of such organization to:

1. Develop and disseminate other health care quality and efficiency information designed to assist businesses and consumers in purchasing health care and long-term care services;

2. Prepare and make public summaries, compilations, or other supplementary reports based on the data provided pursuant to this chapter;

3. Collect, compile, and publish Health Employer Data and Information Set (HEDIS) information or reports or other quality of care or performance information sets approved by the Board, pursuant to § 32.1-276.5, and submitted by health maintenance organizations or other health care plans;

4. Jointly determine with the Board of Medicine any data concerning safety services and quality health care services rendered by physicians to Medicaid recipients that should be identified, collected, and disseminated. The board of directors shall further determine jointly with the Board of Medicine the costs of requiring physicians to identify, submit, or collect such information and identify sufficient funding sources to appropriate to physicians for the collection of the same. No physician shall be required to collect or submit safety and quality of health care services information that is already identified, collected, or submitted under this chapter; or for which funds for collection are not appropriated;

5. Maintain the confidentiality and security of data as set forth in §§ 32.1-276.7:1 and 32.1-276.9;

6. Submit a report to the Board, the Governor, and the General Assembly no later than October 1 of each year for the preceding fiscal year. Such report shall include a certified audit, including an analysis of the efficacy and value of the All-Payer Claims Database, and provide information on the accomplishments, priorities, and current and planned activities of the nonprofit organization;

7. Submit, as appropriate, strategic plans to the Board, the Governor, and the General Assembly recommending specific data projects to be undertaken and specifying data elements for collection under this chapter. In developing strategic plans, the nonprofit organization shall incorporate similar activities of other public and private entities to maximize the quality of data projects and to minimize the cost and duplication of data projects. In its strategic plans, the nonprofit organization shall also evaluate the continued need for and efficacy of current data initiatives, including the use of patient level data for public health purposes. The approval of the General Assembly shall be required prior to the implementation of any recommendations set forth in a strategic plan submitted pursuant to this section;

8. Competitively bid or competitively negotiate all aspects of all data projects, if feasible; and

9. Fulfill all funded requirements set forth for the nonprofit organization in this chapter.

C. The Department shall take steps to increase public awareness of the data and information available through the nonprofit organization's website and how consumers can use the data and information when making decisions about health care providers and services.

D. Except as provided in subdivision A 2 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 Commissioner authorized by this section. Funding for services provided pursuant to any such contract or agreement shall come from general appropriations and from fees determined pursuant to § 32.1-276.8 and from such fees and other public and private funding sources as may be authorized by this chapter.

1996, c. 902; 2000, c. 897; 2006, c. 426; 2010, c. 416; 2012, cc. 693, 709.

§ 32.1-276.5. Providers to submit data; civil penalty.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section. Such data shall include relevant

data and information for any parent or subsidiary company of the health care provider that operates in the Commonwealth. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

C. Every medical care facility as that term is defined in § 32.1-3 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.

Every medical care facility for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report to the Commissioner data on charity care, as that term is defined in § 32.1-102.1, provided to satisfy a condition of a certificate of public need, including (i) the total amount of such charity care the facility provided to indigent persons; (ii) the number of patients to whom such charity care was provided; (iii) the specific services delivered to patients that are reported as charity care recipients; and (iv) the portion of the total amount of such charity care provided that each service represents. The value of charity care reported shall be based on the medical care facility's submission of applicable Diagnosis Related Group codes and Current Procedural Terminology codes aligned with methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Notwithstanding the foregoing, every nursing home as defined in § 32.1-123 for which a certificate of public need with conditions

imposed pursuant to § 32.1-102.4 is issued shall report data on utilization and other data in accordance with regulations of the Board.

A medical care facility that fails to report data required by this subsection shall be subject to a civil penalty of up to $100 per day per violation, which shall be collected by the Commissioner and paid into the Literary Fund.

D. Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data.

E. Every hospital that receives a disproportionate share hospital adjustment pursuant to § 1886(d)(5)(F) of the Social Security Act shall report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, the number of inpatient days attributed to patients eligible for Medicaid but not Medicare Part A and the total amount of the disproportionate share hospital adjustment received.

F. Every hospital shall annually report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, data and information regarding (i) the amount of charity care, discounted care, or other financial assistance provided by the hospital under its financial assistance policy pursuant to § 32.1-137.09 and (ii) the amount of uncollected bad debt, including any uncollected bad debt from payment plans entered into in accordance with subsection C of § 32.1-137.09.

G. The Board shall evaluate biennially the impact and effectiveness of such data collection.

1996, c. 902; 2000, c. 897; 2006, c. 426; 2009, c. 175; 2013, c. 515; 2017, c. 791; 2018, c. 596; 2020, c. 1271; 2022, cc. 678, 679.

§ 32.1-276.5:1. Repealed.

Repealed by Acts 2012, cc. 693 and 709, cl. 2, effective May 11, 2017.

§ 32.1-276.6. Patient level data system continued; reporting requirements.

A. The Virginia Patient Level Data System is hereby continued, hereinafter referred to as the "System." Its purpose shall be to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions.

B. Every inpatient hospital shall submit to the Board patient level data as set forth in this subsection. Every general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title and every physician and every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709.1

performing surgical procedures in his office shall also submit to the board outpatient surgical data as set forth in this subsection. Every oral and maxillofacial surgeon certified to perform certain procedures pursuant to § 54.1-2709 shall submit to the Board outpatient surgical data as set forth in this subsection for only those procedures for which certification is required pursuant to § 54.1-2709.1.

Any such hospital, facility, physician or oral and maxillofacial surgeon, as defined in § 32.1-276.3, may report the required data directly to the nonprofit organization cited in § 32.1-276.4. Unless otherwise noted, patient level data elements for hospital inpatients and patients having outpatient surgery shall include, where applicable and included on standard claim forms:

1. Hospital identifier;

2. Attending physician identifier (inpatient only);

3. Operating physician or oral and maxillofacial surgeon identifier;

4. Payor identifier;

5. Employer identifier as required on standard claims forms;

6. Patient identifier (all submissions);

7. Patient sex, race (inpatient only), date of birth (including century indicator), street address, city or county, zip code, employment status code, status at discharge, and birth weight for infants (inpatient only);

8. Admission type, source (inpatient only), date and hour, and diagnosis;

9. Discharge date (inpatient only) and status;

10. Principal and secondary diagnoses;

11. External cause of injury;

12. Co-morbid conditions existing but not treated;

13. Procedures and procedure dates;

14. Revenue center codes, units, and charges as required on standard claims forms; and

15. Total charges.

C. State agencies providing coverage for outpatient services shall submit to the Board patient level data regarding paid outpatient claims. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;

2. Patient identifier;

3. Physician or oral and maxillofacial surgeon identifier;

4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and

5. Other related information.

The Board shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 32.1-276.4.

1996, c. 902; 2001, c. 341; 2003, c. 466; 2009, c. 652.

§ 32.1-276.7. Methodology to review and measure the efficiency and productivity of health care providers.

A. Pursuant to the contract identified in § 32.1-276.4, and consistent with recommendations set forth in strategic plans submitted and approved pursuant to § 32.1-276.4, the nonprofit organization shall administer and modify, as appropriate, the methodology to review and measure the efficiency and productivity of health care providers. The methodology shall provide for, but not be limited to, comparisons of a health care provider's performance to national and regional data, where available, and may include different methodologies and reporting requirements for the assessment of the various types of health care providers which report to it. Health care providers shall submit the data necessary for implementation of the requirements of this section pursuant to regulations of the Board. Individual health care provider filings shall be open to public inspection once they have been received pursuant to the methodology adopted by the Board as required by this section.

B. The data reporting requirements of this section shall not apply to those health care providers enumerated in (iv) and (v) of the definition of health care providers set forth in § 32.1-276.3 until a strategic plan submitted pursuant to § 32.1-276.4 is approved requiring such reporting and any implementing laws and regulations take effect.

1996, c. 902.

§ 32.1-276.7:1. All-Payer Claims Database created; purpose; reporting requirements.

A. The Virginia All-Payer Claims Database is hereby created to facilitate data-driven, evidence-based improvements in access, quality, and cost of health care and to promote and improve the public health through the understanding of health care expenditure patterns and operation and performance of the health care system.

B. The Commissioner shall ensure that the Department meets the requirements to be a health oversight agency as defined in 45 C.F.R. § 164.501.

C. The Commissioner, in cooperation with the Bureau of Insurance, shall collect paid claims data for covered benefits from data suppliers, which shall include:

1. Issuers of individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; corporations providing individual or group accident and sickness subscription contracts; and health maintenance organizations

providing a health care plan for health care services, for at least 1,000 covered lives in the most recent calendar year;

2. Third-party administrators and any other entities that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, at least 1,000 Virginia covered lives on behalf of group health plans other than ERISA plans;

3. Third-party administrators, and any other entities, that receive or collect charges, contributions, or premiums for, or adjust or settle health care claims for, an employer that maintains an ERISA plan that has opted-in to data submission to the All-Payer Claims Database pursuant to subsection P;

4. The Department of Medical Assistance Services with respect to services provided under programs administered pursuant to Titles XIX and XXI of the Social Security Act;

5. State government health insurance plans;

6. Local government health insurance plans, subject to their ability to provide such data and to the extent permitted by state and federal law; and

7. Federal health insurance plans, to the extent permitted by federal law, including Medicare, TRICARE, and the Federal Employees Health Benefits Plan.

Such collection of paid claims data for covered benefits shall not include data related to Medigap, disability income, workers' compensation claims, standard benefits provided by long-term care insurance, disease specific health insurance, dental or vision claims, or other supplemental health insurance products;

D. The Commissioner shall ensure that the nonprofit organization executes a standard data submission and use agreement with each entity listed in subsection B that submits paid claims data to the All-Payer Claims Database and each entity that subscribes to data products and reports. Such agreements shall include procedures for submission, collection, aggregation, and distribution of specified data. Additionally, the Commissioner shall ensure that the nonprofit organization:

1. Protects patient privacy and data security pursuant to provisions of this chapter and state and federal privacy laws, including the federal Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq., as amended); Titles XIX and XXI of the Social Security Act; § 32.1-127.1:03; Chapter 6 (§ 38.2-600 et seq.) of Title 38.2; and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as included in the American Recovery and Reinvestment Act (P.L. 111-5, 123 Stat. 115) as if the nonprofit organization were covered by such laws;

2. Identifies the type of paid claims to be collected by the All-Payer Claims Database and the entities that are subject to the submission of such claims as well as identification of specific data elements from existing claims systems to be submitted and collected, including but not limited to patient demographics, diagnosis and procedure codes, provider information, plan payments, member payment responsibility, and service dates;

3. Administers the All-Payer Claims Database in a manner to allow for geographic, demographic, economic, and peer group comparisons;

4. Develops public analyses identifying and comparing health plans by public and private health care purchasers, providers, employers, consumers, health plans, health insurers, and data analysts, health insurers, and providers with regard to their provision of safe, cost-effective, and high-quality health care services;

5. Uses common data layout or other national data collection standards and methods that utilize a standard set of core data elements for data submissions, as adopted or endorsed by the APCD Council, to establish and maintain the database in a cost-effective manner and to facilitate uniformity among various all-payer claims databases of other states and specification of data fields to be included in the submitted claims, consistent with such national standards, allowing for exemptions when submitting entities do not collect the specified data or pay on a per-claim basis, such exemption process to be managed by the advisory committee created pursuant to subsection E;

6. Does not disclose or report provider-specific, facility-specific, or carrier-specific reimbursement information, or information capable of being reverse-engineered, combined, or otherwise used to calculate or derive such reimbursement information, from the All-Payer Claims Database;

7. Promotes the responsible use of claims data to improve health care value and preserve the integrity and utility of the All-Payer Claims Database; and

8. Requires that all public reports and analyses comparing providers or health plans using data from the All-Payer Claims Database use national standards or, when such national standards are unavailable, provide full transparency to providers or health plans of the alternative methodology used.

E. The Commissioner shall establish an advisory committee to assist in the formation and operation of the All-Payer Claims Database. Such committee shall consist of (i) a representative from each of the following: a statewide hospital association, a statewide association of health plans, a professional organization representing physicians, a professional organization representing pharmacists, an organization that processes insurance claims or certain aspects of employee benefits plans for a separate entity, a community mental health center who has experience in behavioral health data collection, a nursing home health care provider who has experience with medical claims data, a nonprofit health insurer, and a for-profit health insurer; (ii) up to two representatives with a demonstrated record of advocating health care issues on behalf of consumers; (iii) two representatives of hospitals or health systems; (iv) an individual with academic experience in health care data and cost-efficiency research; (v) a representative who is not a supplier or broker of health insurance from small employers that purchase group health insurance for employees; (vi) a representative who is not a supplier or broker of health insurance from large employers that purchase health insurance for employees, and (vii) a representative who is not a supplier or broker of health insurance from self-insured employers, all of whom shall be appointed by the Commissioner. The Commissioner, the chairman of the board of directors of the nonprofit organization, the Commissioner of Insurance, the Director of the Department of

Medical Assistance Services, the Director of the Department of Human Resource Management, or their designees, shall serve ex officio.

In appointing members to the advisory committee, the Commissioner shall adopt reasonable measures to select representatives in a manner that provides balanced representation within and among the appointments and that any representative appointed is without any actual or apparent conflict of interest, including conflicts of interest created by virtue of the individual's employer's corporate affiliations or ownership interests.

The nonprofit organization shall provide the advisory committee with details at least annually on the use and disclosure of All-Payer Claims Database data, including reports developed by the nonprofit organization; details on methods used to extract, transform, and load data; and efforts to protect patient privacy and data security.

The meetings of the advisory committee shall be open to the public.

F. The Commissioner shall establish a data release committee to review and approve requests for access to data. The data release committee shall consist of the Commissioner or his designee, and upon recommendation of the advisory committee, the Commissioner shall appoint an individual with academic experience in health care data and cost-efficiency research; a representative of a health insurer; a health care practitioner; a representative from a hospital with a background in administration, analytics, or research; and a representative with a demonstrated record of advocating health care issues on behalf of consumers. In making its recommendations, the advisory committee shall adopt reasonable measures to select representatives in a manner that provides balanced representation within and among the appointments and that any representative appointed is without any actual or apparent conflict of interest, including conflicts of interest created by virtue of the individual's employer's corporate affiliations or ownership interests. The data release committee shall ensure that (i) all data approvals are consistent with the purposes of the All-Payer Claims Database as provided in subsection A; (ii) all data approvals comply with applicable state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services; and (iii) the level of detail, as provided in subsection H, is appropriate for each request and is accompanied by a standardized data use agreement.

G. The nonprofit organization shall implement the All-Payer Claims Database, consistent with the provisions of this chapter, to include:

1. The reporting of data that can be used to improve public health surveillance and population health, including reports on (i) injuries; (ii) chronic diseases, including but not limited to asthma, diabetes, cardiovascular disease, hypertension, arthritis, and cancer; (iii) health conditions of pregnant women, infants, and children; and (iv) geographic and demographic information for use in community health assessment, prevention education, and public health improvement. This data shall be developed in a format that allows comparison of information in the All-Payer Claims Database with other nationwide

data programs and that allows employers to compare their employee health plans statewide and between and among regions of the Commonwealth and nationally.

2. The reporting of data that payers, providers, and health care purchasers, including employers and consumers, may use to compare quality and efficiency of health care, including development of information on utilization patterns and information that permits comparison of health plans and providers statewide between and among regions of the Commonwealth. The advisory committee created pursuant to subsection E shall make recommendations to the nonprofit organization on the appropriate level of specificity of reported data in order to protect patient privacy and to accurately attribute services and resource utilization rates to providers.

3. The reporting of data that permits design and evaluation of alternative delivery and payment models.

4. The reporting and release of data consistent with the purposes of the All-Payer Claims Database as set forth in subsection A as determined to be appropriate by the data release committee created pursuant to subsection F.

H. Except as provided in subsection O, the nonprofit organization shall not provide data or access to data without the approval of the data release committee. Upon approval, the nonprofit organization may provide data or access to data at levels of detail that may include (i) aggregate reports, which are defined as data releases with all observation counts greater than 10; (ii) de-identified data sets that meet the standard set forth in 45 C.F.R. § 164.514(a); and (iii) limited data sets that comply with the National Institutes of Health guidelines for release of personal health information.

I. Reporting of data shall not commence until such data has been processed and verified at levels of accuracy consistent with existing nonprofit organization data standards. Prior to public release of any report specifically naming any provider or payer, or public reports in which an individual provider or payers represents 60 percent or more of the data, the nonprofit organization shall provide affected entities with notice of the pending report and allow for a 30-day period of review to ensure accuracy. During this period, affected entities may seek explanations of results and correction of data that they prove to be inaccurate. The nonprofit organization shall make these corrections prior to any public release of the report. At the end of the review period, upon completion of all necessary corrections, the report may be released. For the purposes of this subsection, "public release" means the release of any report to the general public and does not include the preparation of reports for, or use of the All-Payer Claims Database by, organizations that have been approved for access by the data release committee and have entered into written agreements with the nonprofit organization.

J. The Commissioner and the nonprofit organization shall consider and recommend, as appropriate, integration of new data sources into the All-Payer Claims Database, based on the findings and recommendations of the advisory committee.

K. Information acquired pursuant to this section shall be confidential and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The reporting and release of

data pursuant to this section shall comply with all state and federal privacy laws and state and federal laws regarding the exchange of price and cost information to protect the confidentiality of the data and encourage a competitive marketplace for health care services.

L. No person shall assess costs or charge a fee to any health care practitioner related to formation or operation of the All-Payer Claims Database. However, a reasonable fee may be charged to health care practitioners who voluntarily access the All-Payer Claims Database for purposes other than data verification.

M. As used in this section, "provider" means a hospital or physician as defined in this chapter or any other health care practitioner licensed, certified, or authorized under state law to provide covered services represented in claims reported pursuant to this section.

N. The Commissioner, in consultation with the board of directors of the nonprofit organization, shall develop short-term and long-term funding strategies for the operation of the All-Payer Claims Database to provide necessary funding in excess of any budget appropriation by the Commonwealth.

O. The nonprofit organization, the Department of Health, the Department of Medical Assistance Services, and the Bureau of Insurance shall have access to data reported by the All-Payer Claims Database pursuant to this section at no cost for the purposes of public health improvement research and activities.

P. Each employer that maintains an ERISA plan may opt-in to allow a third-party administer or other entity to submit data to the All-Payer Claims Database. For any such employer that opts-in, the third-party administrator or other entity shall (i) submit data for the next reporting period after the opt-in and all future reporting periods until the employer opts-out and (ii) include data from any such employer as part of its data submission, if any, otherwise required by this section. Such an employer may opt-out at any time but shall provide written notice to the third-party administrator or other entity of its decision at least 30 days prior to the start of the next reporting period. No employer that maintains an ERISA plan shall be required to opt-in to data submission to the All-Payer Claims Database, and no third-party administrator or other entity shall be required to submit claims processed before it was contracted to provide services. Each third-party administrator or other entity providing claim administration services for an employer shall submit annually to the nonprofit organization by January 31 of each year a list of the ERISA plans whose employer has opted-in to data submission to the All-Payer Claims Database and a list identifying all employers that maintain an ERISA plan with Virginia employees for which it provides claim administration services. Such information submitted shall be considered proprietary and shall be exempt from disclosure by the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

Q. Any data release shall make use of a masked proxy reimbursement amount, for which the methodology is publicly available and approved by the data release committee except that the Department may request that the nonprofit organization generate the following reports based on actual reimbursement amounts: (i) the total cost burden of a disease, chronic disease, injury, or health condition across the state, health planning region, health planning district, county, or city, provided that the total

cost shall be an aggregate amount encompassing costs attributable to all data suppliers and not identifying or attributable to any individual provider, and (ii) any analyses to determine the average reimbursement that is paid for health care services that may include inpatient and outpatient diagnostic services, surgical services or the treatment of certain conditions or diseases. Any additional report of analysis based on actual reimbursement amounts shall require the approval of the data release committee.

R. The nonprofit organization shall ensure the timely reporting of information by private data suppliers to meet the requirements of this section. The nonprofit organization shall notify private data suppliers of any applicable reporting deadlines. The nonprofit shall notify, in writing, a private data supplier of a failure to meet a reporting deadline, and that failure to respond within two weeks following receipt of the written notice may result in a penalty. The Board may assess a civil penalty of up to $1,000 per week per violation, not to exceed a total of $50,000 per violation, against a private data supplier that fails, within its determination, to make a good faith effort to provide the requested information within two weeks following receipt of the written notice required by this subsection. Civil penalties assessed under this subsection shall be maintained by the Department and used for the ongoing improvement of the All-Payer Claims Database.

2012, cc. 693, 709; 2019, cc. 672, 673.

§ 32.1-276.8. Fees for processing, verification, and dissemination of data.

A. The Board shall prescribe a reasonable fee for each affected health care provider to cover the costs of the reasonable expenses of establishing and administering the methodology developed pursuant to § 32.1-276.7. The payment of such fees shall be at such time as the Board designates. The Board may assess a late charge on any fees paid after their due date.

In addition, the Board shall prescribe a tiered-fee structure based on the number of enrollees for each health maintenance organization to cover the costs of collecting and making available such data. Such fees shall not exceed $3,000 for each health maintenance organization required to provide information pursuant to this chapter. The payment of such fees shall also be at such time as the Board designates. The Board may also assess a late charge on any fees paid by health maintenance organizations after their due dates.

B. Except for the fees assessed pursuant to subsection A, the nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 shall not assess any fee against any health care provider that submits data under this chapter that is processed, verified, and timely in accordance with standards established by the Board. The Board shall establish penalties for submission of data in a manner that is inconsistent with such standards.

C. State agencies shall not be assessed fees for the submission of patient level data required by subsection C of § 32.1-276.6. Individual employers, insurers, and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative ana-

lysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

D. The nonprofit organization providing services pursuant to an agreement or contract with the Commissioner of Health shall be authorized to charge and collect reasonable fees for the dissemination of patient level data and Health Employer Data and Information Set (HEDIS) data or other approved quality of care or performance information set data; however, the Commissioner of Health, the State Corporation Commission, and the Commissioner of Behavioral Health and Developmental Services shall be entitled to receive relevant and appropriate data from the nonprofit organization at no charge.

E. The Board shall (i) maintain records of its activities; (ii) collect and account for all fees and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid; and (iii) enforce all regulations promulgated by it pursuant to this chapter.

1996, c. 902; 1999, c. 764; 2000, c. 897; 2001, c. 341; 2003, c. 472; 2009, cc. 813, 840.

§ 32.1-276.9. Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected pursuant to this chapter shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this chapter; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which may be released solely for research purposes if otherwise permitted by law and only if such identifier is encrypted and cannot be reasonably expected to reveal patient identities. No report published by the nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient. The nonprofit organization, in its discretion, may release physician and employer identifier information. Outpatient surgical charge data shall be made publicly available only pursuant to a review by the Joint Commission on Health Care.

B. No person or entity, including the nonprofit organization contracting with the Commissioner, shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

C. Any disclosure of information made in violation of this chapter shall be subject to a civil penalty of not more than $5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this art-

icle shall be entitled to initiate an action to recover actual damages, if any, or $500, whichever is greater, together with reasonable attorney's fees and court costs.

1996, c. 902; 2001, c. 341.

§ 32.1-276.9:1. Health information needs related to reform; work group.

A. The Commissioner shall direct the nonprofit organization to establish a work group to study continuing health information needs and to develop recommendations for design, development, and operation of systems and strategies to meet those needs. The work group shall include representatives of the Department of Health, the Department of Medical Assistance Services, the Department of Health Professions, the State Corporation Commission's Bureau of Insurance, the Virginia Health Reform Initiative, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, health care providers, and other stakeholders and shall:

1. Identify various health information needs related to implementation of health care reform initiatives, including those associated with development and operation of an all-payer claims database, the Virginia Health Information Exchange, the Virginia Health Benefit Exchange, and any other health reform initiatives. In doing so, the work group shall identify the clinical and paid claims information required and the purposes for which such information will be used; and

2. Identify opportunities for maximizing efficiency and effectiveness of health information systems, reducing duplication of effort related to collection of health information, and minimizing costs and risks associated with collection and use of health information.

B. The Commissioner shall report on activities, findings, and recommendations of the work group annually to the Governor and the General Assembly no later than December 1 of each year, beginning in 2014.

2012, cc. 693, 709.

§ 32.1-276.10. Chapter and actions thereunder not to be construed as approval of charges or costs.

Nothing in this chapter or the actions taken by the Board pursuant to any of its provisions shall be construed as constituting approval by the Commonwealth or any of its agencies or officers of the reasonableness of any charges made or costs incurred by any health care provider.

1996, c. 902.

§ 32.1-276.11. Violations.

Any person violating the provisions of this chapter may be enjoined from continuing such violation by application by the Board for relief to a circuit court having jurisdiction over the offending party.

1996, c. 902.

Chapter 8 - POSTMORTEM EXAMINATIONS AND SERVICES

Article 1 - Chief Medical Examiner and Postmortem Examinations

§ 32.1-277. Office of the Chief Medical Examiner; central and district offices and facilities.

The Commissioner shall establish and maintain, for the purpose of conducting medicolegal investigations of deaths and postmortem examinations, an Office of the Chief Medical Examiner, which shall include a central office and facilities and such district offices and facilities in such localities in the Commonwealth as may be necessary to carry out the provisions of this article. The central office and each district office established pursuant to this section shall be under the supervision of the Chief Medical Examiner. Each such office and facility shall have adequate professional, technical, and medical investigative personnel and physical facilities for the conduct of such examinations and investigations as may be authorized or required by law.

Code 1950, § 32-31.12; 1960, c. 366; 1972, c. 741; 1975, c. 475; 1979, c. 711; 1998, c. 217; 2014, c. 583; 2019, c. 168.

§ 32.1-278. Appointment and qualifications of Chief Medical Examiner.

A Chief Medical Examiner, who shall be a forensic pathologist licensed to practice medicine in this Commonwealth, shall be appointed by the Commissioner with the approval of the Board.

Code 1950, § 32-31.10; 1960, c. 366; 1975, c. 475; 1979, c. 711.

§ 32.1-279. (Effective until date pursuant to Acts 2023, cc. 756 and 778, cl. 5) Duties of Chief Medical Examiner; teaching legal medicine.

A. The Chief Medical Examiner shall carry out the provisions of this article under the direction of the Commissioner. The Chief Medical Examiner may, with the approval of the Commissioner, employ forensic pathologists to serve as Assistant Chief Medical Examiners in the central and district offices established pursuant to § 32.1-277.

B. The Chief Medical Examiner and Assistant Chief Medical Examiners shall be available to Virginia Commonwealth University, the University of Virginia, the Eastern Virginia Medical School, and other institutions of higher education providing instruction in health science or law for teaching legal medicine and other subjects related to their duties.

Code 1950, § 32-31.12; 1960, c. 366; 1972, c. 741; 1975, c. 475; 1979, c. 711; 1991, c. 454; 2002, cc. 87, 478; 2014, c. 583.

§ 32.1-279. (Effective pursuant to Acts 2023, cc. 756 and 778, cl. 5) Duties of Chief Medical Examiner; teaching legal medicine.

A. The Chief Medical Examiner shall carry out the provisions of this article under the direction of the Commissioner. The Chief Medical Examiner may, with the approval of the Commissioner, employ forensic pathologists to serve as Assistant Chief Medical Examiners in the central and district offices established pursuant to § 32.1-277.

B. The Chief Medical Examiner and Assistant Chief Medical Examiners shall be available to Virginia Commonwealth University, the University of Virginia, Old Dominion University, and other institutions of higher education providing instruction in health science or law for teaching legal medicine and other subjects related to their duties.

Code 1950, § 32-31.12; 1960, c. 366; 1972, c. 741; 1975, c. 475; 1979, c. 711; 1991, c. 454; 2002, cc. 87, 478; 2014, c. 583; 2023, cc. 756, 778.

§ 32.1-280. Repealed.

Repealed by Acts 2014, c. 583, cl. 2.

§ 32.1-281. Commissioner may obtain additional services and facilities.

In the investigation of any death or for the performance of any autopsy authorized or required pursuant to this article, the Commissioner may enter into an agreement for the provision of services with a qualified pathologist or consultant, designated by the Chief Medical Examiner, to perform such autopsy or to make such studies and investigations as may be deemed necessary or advisable by the Chief Medical Examiner and may arrange for the use of mortuary facilities. In any case in which the Commissioner enters into an agreement for the provision of services with a qualified pathologist or consultant in accordance with this section, the cost of such services shall be paid out of funds appropriated for such purpose.

Code 1950, § 32-31.15; 1960, c. 366; 1972, c. 741; 1975, c. 475; 1979, c. 711; 1998, c. 217; 2014, c. 583.

§ 32.1-282. Medical examiners.

A. The Chief Medical Examiner may appoint for each county and city one or more medical examiners, who shall be licensed as a doctor of medicine or osteopathic medicine, a physician assistant, or an advanced practice registered nurse in the Commonwealth and appointed as agents of the Commonwealth, to assist the Office of the Chief Medical Examiner with medicolegal death investigations. A physician assistant appointed as a medical examiner shall practice in accordance with § 54.1-2952. An advanced practice registered nurse appointed as a medical examiner shall practice in accordance with § 54.1-2957.

B. At the request of the Chief Medical Examiner, the Assistant Chief Medical Examiner, or their designees, medical examiners may assist the Office of the Chief Medical Examiner with cases requiring medicolegal death investigations in accordance with § 32.1-283.

C. The term of each medical examiner appointed, other than an appointment to fill a vacancy, shall begin on the first day of October of the year of appointment. The term of each medical examiner shall be three years; however, an appointment to fill a vacancy shall be for the unexpired term.

Code 1950, § 32-31.16; 1952, c. 318; 1960, c. 366; 1975, c. 475; 1979, c. 711; 2014, c. 583; 2015, c. 107; 2017, c. 170; 2018, c. 776; 2022, c. 151; 2023, c. 183.

§ 32.1-282.1. Per diem medicolegal death investigators.

The Chief Medical Examiner may appoint per diem medicolegal death investigators, who shall have knowledge of standards and procedures for medicolegal death investigations, to assist the Office of the Chief Medical Examiner with medicolegal death investigations. Per diem medicolegal death investigators shall be agents of the Commonwealth.

2015, c. 53.

§ 32.1-283. Investigation of deaths; obtaining consent to removal of organs, etc.; fees.

A. Upon the death of any person from trauma, injury, violence, poisoning, accident, suicide, or homicide, or suddenly when in apparent good health, or when unattended by a physician, or in jail, prison, or other correctional institution, or in police custody, or who was at the time of his death, or immediately prior to admission to another hospital, an individual receiving services in a state hospital or training center operated by the Department of Behavioral Health and Developmental Services whether the death of such individual was expected or unexpected, or suddenly as an apparent result of fire, or in any suspicious, unusual, or unnatural manner, or the sudden death of any infant, the Office of the Chief Medical Examiner shall be notified by the physician in attendance, hospital, law-enforcement officer, funeral director, or any other person having knowledge of such death. Good faith efforts shall be made by any person or institution having initial custody of the dead body to identify and to notify the next of kin of the decedent. Notification shall include informing the person presumed to be the next of kin that he has a right to have identification of the decedent confirmed without due delay and without being held financially responsible for any procedures performed for the purpose of the identification. Identity of the next of kin, if determined, shall be provided to the Office of the Chief Medical Examiner upon transfer of the dead body.

B. Upon being notified of a death as provided in subsection A, the Office of the Chief Medical Examiner shall take charge of the dead body and the Chief Medical Examiner shall cause an investigation into the cause and manner of death to be made and a full report, which shall include written findings, to be prepared. In order to facilitate the investigation, the Office of the Chief Medical Examiner is authorized to inspect and copy the pertinent medical records of the decedent whose death is the subject of the investigation. Full directions as to the nature, character, and extent of the investigation to be made in such cases shall be furnished each medical examiner appointed pursuant to § 32.1-282 by the Office of the Chief Medical Examiner, together with appropriate forms for the required reports and instructions for their use. The facilities and personnel of the Office of the Chief Medical Examiner shall be made available to any medical examiner investigating a death in accordance with this section. Reports and findings of the Office of the Chief Medical Examiner shall be confidential and shall not under any circumstance be disclosed or made available for discovery pursuant to a court subpoena or otherwise, except as provided in this chapter. Nothing in this subsection shall prohibit the Office of the Chief Medical Examiner from releasing the cause or manner of death or prohibit disclosure of reports or findings to the parties in a criminal case.

C. A copy of each report pursuant to this section shall be delivered to the appropriate attorney for the Commonwealth and to the appropriate law-enforcement agency investigating the death. A copy of any such report regarding the death of a victim of a traffic accident shall be furnished upon request to the State Police and the Highway Safety Commission. In addition, a copy of any report concerning an individual who was receiving services, or who immediately prior to admission to another hospital received services, in a state hospital or training center operated by the Department of Behavioral Health and Developmental Services shall be delivered to the Commissioner of Behavioral Health and

Developmental Services and to the State Inspector General. A copy of any autopsy report concerning a prisoner committed to the custody of the Director of the Department of Corrections shall, upon request of the Director of the Department of Corrections, be delivered to the Director of the Department of Corrections. A copy of any autopsy report concerning a prisoner committed to any local correctional facility shall be delivered to the local sheriff or superintendent. Upon request, the Office of the Chief Medical Examiner shall release such autopsy report to the decedent's attending physician and to the personal representative or executor of the decedent. At the discretion of the Chief Medical Examiner, an autopsy report may be released to the following persons in the following order of priority: (i) the spouse of the decedent, (ii) an adult son or daughter of the decedent, (iii) either parent of the decedent, (iv) an adult sibling of the decedent, (v) any other adult relative of the decedent in order of blood relationship, or (vi) any appropriate health facility quality assurance program.

D. For each investigation under this article, including the making of the required reports, the medical examiner appointed pursuant to § 32.1-282 shall receive a fee established by the Board within the limitations of appropriations for the purpose. Such fee shall be paid by the Commonwealth if the deceased is not a legal resident of the county or city in which his death occurred. In the event the deceased is a legal resident of the county or city in which his death occurred, such county or city shall be responsible for the fee up to $20. If the deceased is an individual who receives services in a state hospital or training center operated by the Department of Behavioral Health and Developmental Services, the fee shall be paid by the Department of Behavioral Health and Developmental Services.

E. Nothing herein shall be construed to interfere with the autopsy procedure or with the routine obtaining of consent for removal of organs as conducted by surgical teams or others.

Code 1950, §§ 32-31.17, 32-31.18, 32-31.20; 1950, p. 659; 1952, cc. 318, 705; 1960, c. 366; 1962, c. 366; 1968, c. 431; 1972, cc. 556, 741; 1974, c. 443; 1975, c. 475; 1978, c. 175; 1979, c. 711; 1981, c. 388; 1985, c. 228; 1993, c. 965; 2002, c. 203; 2003, c. 368; 2007, cc. 19, 868; 2008, cc. 287, 433; 2009, cc. 813, 840; 2011, cc. 798, 871; 2012, cc. 476, 507; 2014, c. 583; 2023, c. 566.

§ 32.1-283.1. State Child Fatality Review Team; membership; access to and maintenance of records; confidentiality; etc.

A. There is hereby created the State Child Fatality Review Team, referred to in this section as "the Team," which shall develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. The Team shall review (i) violent and unnatural child deaths, (ii) sudden child deaths occurring within the first 18 months of life, and (iii) those fatalities for which the cause or manner of death was not determined with reasonable medical certainty. No child death review shall be initiated by the Team until conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide

technical assistance, upon request, to any local child fatality teams that may be established. The operating procedures for the review of child deaths shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision B 17 of § 2.2-4002.

B. The 16-member Team shall be chaired by the Chief Medical Examiner and shall be composed of the following persons or their designees: the Commissioner of Behavioral Health and Developmental Services; the Director of Child Protective Services within the Department of Social Services; the Superintendent of Public Instruction; the State Registrar of Vital Records; and the Director of the Department of Criminal Justice Services. In addition, one representative from each of the following entities shall be appointed by the Governor to serve for a term of three years: local law-enforcement agencies, local fire departments, local departments of social services, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Pediatric Society, local emergency medical services personnel, attorneys for the Commonwealth, and community services boards.

C. Upon the request of the Chief Medical Examiner in his capacity as chair of the Team, made after the conclusion of any law-enforcement investigation or prosecution, information and records regarding a child whose death is being reviewed by the Team may be inspected and copied by the Chief Medical Examiner or his designee, including, but not limited to, any report of the circumstances of the event maintained by any state or local law-enforcement agency or medical examiner, and information or records maintained on such child by any school, social services agency or court. Information, records, or reports maintained by any attorney for the Commonwealth shall be made available for inspection and copying by the Chief Medical Examiner pursuant to procedures which shall be developed by the Chief Medical Examiner and the Commonwealth's Attorneys' Services Council established by § 2.2-2617. Any presentence report prepared pursuant to § 19.2-299 for any person convicted of a crime that led to the death of the child shall be made available for inspection and copying by the Office of the Chief Medical Examiner pursuant to procedures which shall be developed by the Chief Medical Examiner. In addition, the Office of the Chief Medical Examiner may inspect and copy from any Virginia health care provider, on behalf of the Team, (i) without obtaining consent, the health and mental health records of the child and those perinatal medical records of the child's mother that related to such child and (ii) upon obtaining consent from each adult regarding his personal records, or from a parent regarding the records of a minor child, the health and mental health records of the child's family. All such information and records shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. Upon the conclusion of the child death review, all information and records concerning the child and the child's family shall be shredded or otherwise destroyed by the Office of the Chief Medical Examiner in order to ensure confidentiality. Such information or records shall not be subject to subpoena or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the Team during a child death review. Further, the findings of the Team may be disclosed

or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual child death cases are discussed by the Team shall be closed pursuant to subdivision A 21 of § 2.2-3711. In addition to the requirements of § 2.2-3712, all team members, persons attending closed team meetings, and persons presenting information and records on specific child deaths to the Team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific child death. Violations of this subsection are punishable as a Class 3 misdemeanor.

D. Upon notification of a child death, any state or local government agency maintaining records on such child or such child's family which are periodically purged shall retain such records for the longer of 12 months or until such time as the State Child Fatality Review Team has completed its child death review of the specific case.

E. The Team shall compile annual data which shall be made available to the Governor and the General Assembly as requested. These statistical data compilations shall not contain any personally identifying information and shall be public records.

1994, c. 643; 1995, c. 499; 1999, cc. 703, 726; 2004, c. 690; 2007, c. 411; 2009, cc. 813, 840; 2014, c. 583; 2017, c. 778.

§ 32.1-283.2. Local and regional child fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, attorney for the Commonwealth's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations are punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § 32.1-283.1.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a medical examiner appointed pursuant to § 32.1-282, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, a local emergency medical services agency chief, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed four, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agen-

cies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations.

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection are punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

1999, c. 867; 2004, c. 690; 2014, c. 583; 2015, cc. 502, 503; 2017, c. 778.

§ 32.1-283.3. Family violence fatality review teams established; model protocol and data management; membership; authority; confidentiality, etc.

A. The Office of the Chief Medical Examiner shall develop a model protocol for the development and implementation of local family violence fatality review teams (teams) and such model protocol shall include relevant procedures for conducting reviews of fatal family violence incidents. A "fatal family

violence incident" means any fatality that occurred or that is suspected of having occurred in the context of abuse between family members or intimate partners. The Office of the Chief Medical Examiner shall provide technical assistance to the local teams and serve as a clearinghouse for information.

B. Subject to available funding, the Office of the Chief Medical Examiner shall provide ongoing surveillance of fatal family violence occurrences and promulgate an annual report based on accumulated data.

C. Any county or city, or combination of counties, cities, or counties and cities, may establish a family violence fatality review team to examine fatal family violence incidents and to create a body of information to help prevent future family violence fatalities. The team shall have the authority to review the facts and circumstances of all fatal family violence incidents that occur within its designated geographic area.

D. Membership in the team may include, but shall not be limited to, health care professionals, representatives from the local bar, attorneys for the Commonwealth, judges, law-enforcement officials, criminologists, medical examiners appointed pursuant to § 32.1-282, other experts in forensic medicine and pathology, family violence victim advocates, health department professionals, probation and parole professionals, adult and child protective services professionals, and representatives of family violence local coordinating councils.

E. Each team shall establish local rules and procedures to govern the review process prior to the first fatal family violence incident review conducted. The review of a death shall be delayed until any criminal investigations or prosecutions connected with the death are completed.

F. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the review nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the

information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection are punishable as a Class 3 misdemeanor.

G. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a family violence fatality review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

1999, cc. 849, 868; 2014, c. 583; 2016, c. 307; 2017, c. 778.

§ 32.1-283.4. Confidentiality of certain information and records collected and maintained by the Office of the Chief Medical Examiner.

A. Confidential records and information obtained from private and public entities and provided to the Office of the Chief Medical Examiner during the course of a death investigation shall remain confidential and shall not be subject to the provisions of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

B. Information and records concerning a decedent collected and maintained by the Office of the Chief Medical Examiner during the course of surveillance programs or research or studies of deaths having public health importance shall be confidential and may only be published in summary or aggregate form or as authorized by the Chief Medical Examiner.

C. The confidential records and information set forth in subsections A and B shall not be subject to subpoena, subpoena duces tecum, or discovery when in the possession of the Office of the Chief Medical Examiner, or be admissible in any criminal or civil proceeding through any discovery relating to the Office. If available from other sources, however, such records and information shall not be immune from subpoena duces tecum, or discovery when obtained through such other sources solely because the records and information were presented to the Office during a death investigation.

D. Nothing in this section shall be construed to prohibit the disclosure or publication of the findings of investigations, surveillance programs, research, and studies in aggregate or statistical form from which personal identifiers have been removed.

2005, c. 37; 2007, c. 868.

§ 32.1-283.5. Adult Fatality Review Team; duties; membership; confidentiality; penalties; report; etc.

A. There is hereby created the Adult Fatality Review Team, referred to in this section as "the Team," which shall develop and implement procedures to ensure that adult deaths occurring in the Commonwealth are analyzed in a systematic way. The Team shall review the death of any person age 60 years or older, or any adult age 18 years or older who is incapacitated, who resides in the Commonwealth, or who does not reside in the Commonwealth but who is temporarily in the Commonwealth and who is in need of temporary or emergency protective services (i) who was the subject

of an adult protective services or law-enforcement investigation; (ii) whose death was due to abuse, neglect, or exploitation or acts suggesting abuse, neglect, or exploitation; or (iii) whose death came under the jurisdiction of or was investigated by the Office of the Chief Medical Examiner pursuant to § 32.1-283. The Team shall not initiate an adult death review until the conclusion of any law-enforcement investigation or criminal prosecution. The operating procedures for the review of adult deaths shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision B 17 of § 2.2-4002.

B. The 16-member team shall consist of the following persons or their designees: the Chief Medical Examiner, the Commissioner of Behavioral Health and Developmental Services, the Commissioner for Aging and Rehabilitative Services, the Director of the Office of Licensure and Certification of the Department of Health, and the State Long-Term Care Ombudsman. In addition, the Governor shall appoint one representative from each of the following entities: a licensed funeral services provider, the Medical Society of Virginia, and local departments of social services, emergency medical services, attorneys for the Commonwealth, law-enforcement agencies, nurses specializing in geriatric care, psychiatrists specializing in geriatric care, and long-term care providers. The Team further shall include two members appointed by the Governor who are advocates for elderly or disabled populations in Virginia. The Chief Medical Examiner shall serve as chair of the Team.

After the initial staggering of terms, members appointed by the Governor shall be appointed for a term of four years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed. The Chief Medical Examiner and other ex officio members of the Team shall serve terms coincident with their terms of office.

C. Upon the request of the chair of the Team, made after the conclusion of any law-enforcement investigation or prosecution, information and records regarding an adult whose death is being reviewed by the Team shall be inspected and copied by the chair or his designee, including but not limited to any report of the circumstances of the event maintained by any state or local law-enforcement agency or the Office of the Chief Medical Examiner and information or records on the adult maintained by any facility that provided services to the adult, by any social services agency, or by any court. Information, records, or reports maintained by any attorney for the Commonwealth shall be made available for inspection and copying by the chair or his designee pursuant to procedures that shall be developed by the Chief Medical Examiner and the Commonwealth's Attorneys' Services Council established by § 2.2-2617. In addition, a health care provider shall provide the Team, upon request, with access to the health and mental health records of (i) the adult whose death is subject to review, without authorization; (ii) any adult relative of the deceased, with authorization; and (iii) any minor child of the deceased, with the authorization of the minor's parent or guardian. The chair of the Team also may copy and inspect the presentence report, prepared pursuant to § 19.2-299, of any person convicted of a crime that led to the death of the adult who is the subject of review by the Team.

D. All information obtained or generated by the Team regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. Such information shall not be subject to subpoena or discovery or be admissible in any civil or criminal proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the Team during an adult death review. The Team shall compile all information collected during a review. The findings of the Team may be disclosed or published in statistical or other form, but shall not identify any individuals. The portions of meetings in which individual adult death cases are discussed by the Team shall be closed pursuant to subdivision A 21 of § 2.2-3711.

E. All Team members and other persons attending closed Team meetings, including any persons presenting information or records on specific fatalities, shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the Team reviews a specific death. No Team member or other person who participates in a review shall be required to make any statement regarding the review or any information collected during the review. Upon conclusion of a review, all information and records concerning the victim and the family shall be shredded or otherwise destroyed in order to ensure confidentiality. Violations of this subsection are punishable as a Class 3 misdemeanor.

F. Upon notification of an adult death, any state or local government agency or facility that provided services to the adult or maintained records on the adult or the adult's family shall retain the records for the longer of 12 months or until such time as the Team has completed its review of the case.

G. The Team shall compile an annual report by October 1 of each year that shall be made available to the Governor and the General Assembly. The annual report shall include any policy, regulatory, or budgetary recommendations developed by the Team. Any statistical compilations prepared by the Team shall be public record and shall not contain any personally identifying information.

2008, c. 539; 2009, cc. 813, 840; 2012, cc. 803, 835; 2014, c. 583; 2015, c. 108; 2017, c. 778.

§ 32.1-283.6. Local and regional adult fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, department of social services, emergency medical services agency, attorney for the Commonwealth's office, community services board, or official with the Adult Protective Services Unit established pursuant to § 51.5-148, local or regional adult fatality review teams may be established for the purpose of conducting contemporaneous reviews of local adult deaths in order to develop interventions and strategies for prevention specific to the locality or region. For the purposes of this section, the team may review the death of any person age 60 years or older, or any adult age 18 years or older who is incapacitated, who resides in the Commonwealth and who is in need of temporary or emergency protective services (i) who was the subject of an adult protective services or law-enforcement investigation; (ii) whose

death was due to abuse, neglect, or exploitation or acts suggesting abuse, neglect, or exploitation; or (iii) whose death came under the jurisdiction of or was investigated by the Office of the Chief Medical Examiner as occurring in any suspicious, unusual, or unnatural manner, pursuant to § 32.1-283. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. A violation of this subsection is punishable as a Class 3 misdemeanor. The Office of the Chief Medical Examiner shall develop a model protocol for the development and implementation of local or regional adult fatality review teams and such model protocol shall include relevant procedures for conducting reviews of adult fatalities.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a medical examiner appointed pursuant to § 32.1-282, a local adult protective services official, a local social services official, a director of the relevant local or district health department, an executive director of the local area agency on aging or other department representing the interests of the elderly or disabled, a chief law-enforcement officer, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, a local judge, and such additional persons as may be appointed to serve by the chair of the local or regional team. The chair shall be elected from among the designated membership. The additional members appointed by the chair may include, but are not restricted to, representatives of local human services agencies, local health care professionals specializing in geriatric care or care of incapacitated adults, local emergency medical services personnel, local long-term care providers, representatives of local advocacy or service organizations for elderly or disabled populations, experts in forensic medicine and pathology, local funeral services providers, local centers for independent living, local long-term care ombudsmen, and representatives of the local bar.

C. Each local or regional team shall establish operating procedures to govern the review process prior to conducting the first adult fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding a review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information and records shall not be subject to subpoena, subpoena duces tecum, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during the fatality review. No person who participated in the review and no member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form that does

not identify any individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. A violation of this subsection is punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in an adult fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports, or records to review teams as part of such review shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

2015, c. 108; 2017, c. 778.

§ 32.1-283.7. Local and regional overdose fatality review teams established; membership; authority; confidentiality; immunity.

A. Any county or city, or combination of counties, cities, or counties and cities, may establish a local or regional overdose fatality review team for the purpose of (i) conducting contemporaneous reviews of local overdose deaths, (ii) promoting cooperation and coordination among agencies involved in investigations of overdose deaths or in providing services to surviving family members, (iii) developing an understanding of the causes and incidence of overdose deaths in the locality, (iv) developing plans for and recommending changes within the agencies represented on the local team to prevent overdose deaths, and (v) advising the Department and other relevant state agencies on changes to law, policy, or practice to prevent overdose deaths.

B. A local or regional team may review the death of any person who resides in the Commonwealth and whose death was or is suspected to be due to overdose. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. A violation of this subsection is punishable as a Class 3 misdemeanor. The Office of the Chief Medical Examiner may develop a model protocol for the development and implementation of local or regional overdose fatality review teams, and such model protocol may include relevant procedures for conducting reviews of overdose fatalities.

C. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a medical examiner appointed pursuant to § 32.1-282, a local social services official, a director of the relevant local or district health department, a chief law-enforcement officer, an attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, a local judge, the local school division superintendent, a representative of a local jail or detention center, and such additional persons as

may be appointed to serve by the chair of the local or regional team. The chair shall be elected from among the designated membership. The additional members appointed by the chair may include representatives of local human services agencies, local health care professionals who specialize in the prevention and treatment of substance abuse disorders, local emergency medical services personnel, a representative of a hospital, experts in forensic medicine and pathology, local funeral services providers, and representatives of the local bar.

D. Each local or regional team shall establish operating procedures to govern the review process prior to conducting the first overdose fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

E. All information and records obtained or created regarding a review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information and records shall not be subject to subpoena, subpoena duces tecum, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during the fatality review. No person who participated in the review and no member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form that does not identify any individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. A violation of this subsection is punishable as a Class 3 misdemeanor.

F. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in an overdose fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports, or records to overdose fatality review teams as part of such review shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

2018, c. 600.

§ 32.1-283.8. Maternal Mortality Review Team; duties; membership; confidentiality; penalties; report; etc.

A. As used in this section, "maternal death" means the death of a woman who was pregnant at the time of death or within one year prior to the time of death, regardless of the outcome of the pregnancy, including any death determined to be a natural death, unnatural death, or violent death or for which no cause of death was determined.

B. There is hereby created the Maternal Mortality Review Team (the Team), which shall develop and implement procedures to ensure that certain maternal deaths occurring in the Commonwealth are analyzed in a systematic way. The Team shall review every maternal death in the Commonwealth. The Team shall not initiate a maternal death review until the conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for maternal death reviews, including identification of cases to be reviewed and procedures for coordinating among the agencies and professionals involved; (ii) improve the identification of and data collection and record keeping related to causes of maternal deaths; (iii) recommend components of programs to increase awareness and prevention of and education about maternal deaths; and (iv) recommend training to improve the review of maternal deaths. Such operating procedures shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision B 17 of § 2.2-4002.

C. The Team shall consist of the following persons or their designees: the Chief Medical Examiner, the Director of the Office of Family Health of the Department of Health, the State Registrar of Vital Records, and the Commissioner of Behavioral Health and Developmental Services. In addition, the Governor shall appoint one representative of each of the following entities: local law enforcement, local fire departments, local emergency medical services providers, local departments of social services, community services boards, attorneys for the Commonwealth, the Medical Society of Virginia, the Virginia Hospital and Healthcare Association, the Virginia College of Emergency Physicians, the Virginia Section of the American College of Obstetricians and Gynecologists, the Virginia Affiliate of the American College of Nurse-Midwives, the Virginia Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, the Virginia Neonatal Perinatal Collaborative, the Virginia Midwives Alliance, and the Virginia Academy of Nutrition and Dietetics. The Chief Medical Examiner and the Director of the Office of Family Health of the Department of Health shall serve as co-chairs of the Team and may appoint additional members of the Team as may be needed to complete maternal death reviews pursuant to this section.

After the initial staggering of terms, members other than the Chief Medical Examiner, the Director of the Office of Family Health of the Department of Health, the State Registrar of Vital Records, the Commissioner of Behavioral Health and Developmental Services, and the Director of the Department of Criminal Justice Services shall be appointed for a term of three years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed. The Chief Medical Examiner, the Director of the Office of Family Health of the Department of Health, the State Registrar of Vital Records, the Commissioner of Behavioral Health and Developmental Services, and the

Director of the Department of Criminal Justice Services shall serve terms coincident with their terms of office.

D. Upon the request of the Chief Medical Examiner in his capacity as a co-chair of the Team, made after the conclusion of any law-enforcement investigation or prosecution, the Chief Medical Examiner or his designee may inspect and copy information and records regarding a maternal death, including (i) any report of the circumstances of the maternal death maintained by any state or local law-enforcement agency or medical examiner, and (ii) information or records about the woman maintained by any social services agency or court. Information, records, or reports maintained by any attorney for the Commonwealth shall be made available for inspection and copying by the Chief Medical Examiner or his designee pursuant to procedures that shall be developed by the Chief Medical Examiner and the Commonwealth's Attorneys' Services Council established by § 2.2-2617. Any presentence report prepared pursuant to § 19.2-299 for any person convicted of a crime that led to the death of the woman shall be made available for inspection and copying by the Chief Medical Examiner or his designee. In addition, the Chief Medical Examiner or his designee may inspect and copy from any health care provider in the Commonwealth, on behalf of the Team, (a) without obtaining consent, subject to any limitations on disclosure under applicable federal and state law, the health and mental health records of the woman and those prenatal medical records relating to any child born to the woman and (b) upon obtaining consent, from each adult regarding his records.

E. All information and records obtained or created by the Team or on behalf of the Team regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the Team only in the exercise of its proper purpose and function and shall not be disclosed. In preparing information and records for review by the Team, the Department shall remove any individually identifiable information or information identifying a health care provider, as those terms are defined in 45 C.F.R. § 160.103. Such information shall not be subject to subpoena, subpoena duces tecum, or discovery, be admissible in any civil or criminal proceeding, or be used as evidence in any disciplinary proceeding or regulatory or licensure action of the Department of Health Professions or any health regulatory board. If available from other sources, however, such information and records shall not be immune from subpoena, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the Team during a maternal death review. The findings of the Team may be disclosed or published in statistical or other form, but shall not identify any individual. Upon conclusion of the maternal death review, all information and records concerning the woman and the woman's family shall be shredded or otherwise destroyed by the Office of the Chief Medical Examiner in order to ensure confidentiality.

The portions of meetings in which individual maternal deaths are discussed by the Team shall be closed pursuant to subdivision A 21 of § 2.2-3711. In addition to the requirements of § 2.2-3712, all Team members and other persons attending closed Team meetings, including any persons presenting information or records on specific maternal deaths to the Team during closed meetings, shall

execute a sworn statement to (i) honor the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the Team reviews a specific maternal death and (ii) not use any such information, records, discussions, or opinions disclosed during meetings at which the Team reviews a specific maternal death for any purpose other than the exercise of the proper purpose and function of the Team. Violations of this subsection are punishable as a Class 3 misdemeanor.

F. Upon notification of a maternal death, any state or local government agency maintaining records on the woman or the woman's family that are periodically purged shall retain such records for the longer of 12 months or until such time as the Team has completed its review of the case.

G. The Team shall compile annual statistical data, which shall be made available to the Governor and the General Assembly. Any statistical compilations prepared by the Team shall be public record and shall not contain any personal identifying information.

H. Members of the Team, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a review by the Team, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports, or records to the Team as part of such review shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

2019, c. 834; 2023, c. 369.

§ 32.1-284. Repealed.

Repealed by acts 2014, c. 228, cl. 2, effective March 7, 2014.

§ 32.1-285. (Effective until January 1, 2024) Autopsies.

A. If, in the opinion of the Office of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy be made as part of the investigation of the death, or if an autopsy is requested by the attorney for the Commonwealth or by a judge of the circuit court of the county or city wherein such body is or where death occurred or wherein any injury contributing to or causing death was sustained, an autopsy shall be performed by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a pathologist with whom the Commissioner has entered into an agreement in accordance with § 32.1-281. Upon petition of a member of the immediate family or the spouse of the deceased in a case of death by injury, such circuit court may, for good cause shown, order an autopsy, after providing notice and an opportunity to be heard to the attorney for the Commonwealth for the jurisdiction wherein the injury contributing to or causing death was sustained or where death occurred. Further, in all cases of death suspected to be attributable to Sudden Infant Death Syndrome (SIDS), an autopsy shall be advisable and in the public interest and shall be performed as required by § 32.1-285.1. A full record and report of the facts developed by the autopsy and findings of the person making such autopsy shall be promptly made and filed with the Office of the Chief Medical Examiner and a copy furnished the judge or attorney for the Commonwealth requesting such autopsy. In the discretion of the Chief Medical Examiner or an Assistant Chief Medical Examiner, a copy of any autopsy report or

findings may be furnished to any appropriate attorney for the Commonwealth and to the appropriate law-enforcement agency investigating the death.

B. In the case of a child death investigation that indicates child abuse or neglect contributed to the death, or that the child suffered from abuse and neglect, the case shall be immediately reported to the child protective services unit of the local Department of Social Services by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

Code 1950, § 32-31.19; 1952, c. 318; 1960, c. 366; 1975, c. 475; 1979, c. 711; 1989, c. 66; 1991, c. 644; 1993, c. 965; 2003, c. 368; 2014, c. 583.

§ 32.1-285.1. Death of infants under eighteen months of age; autopsies required; definition of Sudden Infant Death Syndrome.

An autopsy shall be performed in the case of any infant death which is suspected to be attributable to Sudden Infant Death Syndrome (SIDS).

For the purposes of this section, "Sudden Infant Death Syndrome" (SIDS), a diagnosis of exclusion, means the sudden and unexpected death of an infant less than eighteen months of age whose death remains unexplained after a thorough postmortem examination which includes an autopsy.

1993, c. 965.

§ 32.1-285. (Effective January 1, 2024) Autopsies.

A. If, in the opinion of the Office of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy be made as part of the investigation of the death, or if an autopsy is requested by the attorney for the Commonwealth or by a judge of the circuit court of the county or city wherein such body is or where death occurred or wherein any injury contributing to or causing death was sustained, or if the decedent is an inmate in the custody of the Department of Corrections, an autopsy shall be performed by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a pathologist with whom the Commissioner has entered into an agreement in accordance with § 32.1-281. Upon petition of a member of the immediate family or the spouse of the deceased in a case of death by injury, such circuit court may, for good cause shown, order an autopsy, after providing notice and an opportunity to be heard to the attorney for the Commonwealth for the jurisdiction wherein the injury contributing to or causing death was sustained or where death occurred. Further, in all cases of death suspected to be attributable to Sudden Infant Death Syndrome (SIDS), an autopsy shall be advisable and in the public interest and shall be performed as required by § 32.1-285.1. A full record and report of the facts developed by the autopsy and findings of the person making such autopsy shall be promptly made and filed with the Office of the Chief Medical Examiner and a copy furnished the judge or attorney for the Commonwealth requesting such autopsy. In the discretion of the Chief Medical Examiner or an Assistant Chief Medical Examiner, a copy of any autopsy report or findings may be furnished to any appropriate attorney for the Commonwealth and to the appropriate law-enforcement agency investigating the death.

B. In the case of a child death investigation that indicates child abuse or neglect contributed to the death, or that the child suffered from abuse and neglect, the case shall be immediately reported to the child protective services unit of the local Department of Social Services by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282.

Code 1950, § 32-31.19; 1952, c. 318; 1960, c. 366; 1975, c. 475; 1979, c. 711; 1989, c. 66; 1991, c. 644; 1993, c. 965; 2003, c. 368; 2014, c. 583; 2023, cc. 477, 478.

§ 32.1-286. Exhumations.

A. In any case of death described in subsection A of § 32.1-283, where the body is buried without investigation by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 into the cause and manner of death or where sufficient cause develops for further investigation after a body is buried, the Chief Medical Examiner shall authorize such investigation and shall send a copy of the report, which shall include the name and contact information of the next of kin, as defined in § 54.1-2800, of the dead person, if known, to the appropriate attorney for the Commonwealth who shall communicate such report to a judge of the appropriate circuit court and forward a copy of such report to the clerk of such court. In cases in which the name and contact information of the next of kin is not known at the time the report is prepared, the Chief Medical Examiner shall so indicate on the report. Upon receipt of such report, the clerk of the court shall send notice of the investigation and any order of exhumation to the next of kin of the dead person when the name and contact information of the next of kin is included in the report. The judge may order that the body be exhumed and an autopsy performed thereon by the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a pathologist with whom the Commissioner has entered into an agreement pursuant to § 32.1-281. The pertinent facts disclosed by an autopsy conducted pursuant to an order entered in accordance with this subsection shall be communicated to the judge who ordered the autopsy.

B. Upon petition of the attorney for the Commonwealth to whom a report is submitted in accordance with subsection A and a finding that good cause exists, a judge for the appropriate circuit court may, for a period of time not to exceed ninety days, order that (i) notification of the next of kin of the dead person be withheld, (ii) the report and order for exhumation be sealed by the clerk of the circuit court, and (iii) any parties involved in the investigation or exhumation not disclose to the next of kin of the dead person or any other person that the court may deem appropriate that the investigation or exhumation has occurred. Upon the petition of the attorney for the Commonwealth and a finding that good cause exists, the court may extend any such time period for additional periods not to exceed ninety days for each extension granted.

C. In any case of death in which a private person has an interest, such person may petition the judge of the circuit court exercising jurisdiction over the place of interment to have the body exhumed. Such petition shall include the name and contact information of the next of kin of the dead person or, in cases in which the name and contact information is not known, an affirmation that good faith efforts to determine the name and contact information have been made. Upon receipt of the petition, the clerk of

the court shall send notice of the petition to the next of kin of the dead person when the name and contact information of the next of kin is included in the petition. Upon proper showing of sufficient cause, such judge may order the body exhumed. Such petition or exhumation or both shall not require the participation of the Chief Medical Examiner or any Assistant Chief Medical Examiner. Costs shall be paid by the party requesting the exhumation.

D. A party attempting to prove, in accordance with the provisions of §§ 64.2-102 and 64.2-103, that he is the issue of a dead person, may petition the judge of the circuit court exercising jurisdiction over the place of interment to have the body exhumed. The petition shall be accompanied by the petitioner's sworn statement that sets forth facts establishing a reasonable possibility of a biological relationship between the petitioner and his alleged ancestors, and shall include the name and contact information of the next of kin of the dead person or, in cases in which the name and contact information is not known, an affirmation that good faith efforts to determine the name and contact information have been made. Upon receipt of the petition, the clerk of the court shall send notice of the petition to the next of kin of the dead person when the name and contact information of the next of kin is included in the petition. The court may order the exhumation of the dead person for the conduct of scientifically reliable genetic tests, including DNA tests, to prove a biological relationship. The costs of exhumation, testing, and reinterment shall be paid by the petitioner unless, for good cause shown, the court orders such costs paid from the estate in which the petitioner is claiming an interest. This provision is intended to provide a procedural mechanism for obtaining posthumous samples for reliable genetic testing and shall not require substantive proof of parentage to obtain the exhumation order.

Code 1950, § 32-31.19; 1952, c. 318; 1960, c. 366; 1975, c. 475; 1979, c. 711; 1997, c. 59; 1999, c. 781; 2013, c. 370; 2014, c. 583; 2016, c. 356.

§ 32.1-287. Repealed.
Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§§ 32.1-288, 32.1-288.1. Repealed.
Repealed by Acts 2014, c. 228, cl. 2, effective March 7, 2014.

Article 2 - ANATOMICAL GIFTS

§ 32.1-289. Repealed.
Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-289.1. Repealed.
Repealed by Acts 2007, c. 92, cl. 2.

§ 32.1-289.2. Repealed.
Repealed by Acts 2021, Sp. Sess. I, c. 465, cl. 2, effective July 1, 2021.

§§ 32.1-290. Repealed.
Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-290.1. Repealed.

Repealed by Acts 2008, c. 82, cl. 2.

§ 32.1-291. Repealed.

Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-291.1. Revised Uniform Anatomical Gift Act; short title.

This Act consists of §§ 32.1-291.1 through 32.1-291.25 and may be cited as the Revised Uniform Anatomical Gift Act.

2007, cc. 92, 907.

§ 32.1-291.2. Definitions.

As used in this Act, unless the context requires otherwise:

"Adult" means an individual who is at least 18 years of age.

"Agent" means an individual:

1. Authorized to make health-care decisions on the principal's behalf by a power of attorney for health care; or

2. Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.

"Anatomical gift" means a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education.

"Decedent" means a deceased individual whose body or part is or may be the source of an anatomical gift. The term includes a stillborn infant and, subject to restrictions imposed by law other than this Act, a fetus.

"Disinterested witness" means a witness other than the spouse, child, parent, sibling, grandchild, grandparent, or guardian of the individual who makes, amends, revokes, or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual. The term does not include a person to whom an anatomical gift could pass under § 32.1-291.11.

"Document of gift" means a donor card or other record used to make an anatomical gift. The term includes a statement or symbol on a driver's license, identification card, or donor registry.

"Donor" means an individual whose body or part is the subject of an anatomical gift.

"Donor registry" means a database that contains records of anatomical gifts.

"Driver's license" means a license or other document issued by the Department of Motor Vehicles under Chapter 3 (§ 46.2-300 et seq.) of Title 46.2 authorizing the operation of a motor vehicle upon the highways, whether or not conditions are attached to the license or other document.

"Eye bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of human eyes or portions of human eyes and that is a member of the Virginia Transplant Council, accredited by the Eye

Bank Association of America or the American Association of Tissue Banks and operating in the Commonwealth of Virginia.

"Guardian" means a person appointed by a court to make decisions regarding the support, care, education, health, or welfare of an individual. The term does not include a guardian ad litem, except when the guardian ad litem is authorized by a court to consent to donation.

"Hospital" means a facility licensed as a hospital under the law of any state or a facility operated as a hospital by the United States, a state, or a subdivision of a state.

"Identification card" means an identification card issued by the Department of Motor Vehicles under Chapter 3 (§ 46.2-300 et seq.) of Title 46.2.

"Know" means to have actual knowledge.

"Minor" means an individual who is under 18 years of age.

"Organ procurement organization" means a person designated by the Secretary of the United States Department of Health and Human Services as an organ procurement organization that is also a member of the Virginia Transplant Council.

"Parent" means a parent whose parental rights have not been terminated.

"Part" means an organ, an eye, or tissue of a human being. The term does not include the whole body.

"Person" means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency, or instrumentality, or any other legal or commercial entity.

"Physician" means an individual authorized to practice medicine or osteopathy under the law of any state.

"Procurement organization" means an eye bank, organ procurement organization, or tissue bank that is a member of the Virginia Transplant Council.

"Prospective donor" means an individual who is dead or whose death is imminent and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research, or education. The term does not include an individual who has made a refusal.

"Reasonably available" means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.

"Recipient" means an individual into whose body a decedent's part has been or is intended to be transplanted.

"Record" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.

"Refusal" means a record created under § 32.1-291.7 that expressly states an intent to bar other persons from making an anatomical gift of an individual's body or part.

"Sign" means, with the present intent to authenticate or adopt a record:

1. To execute or adopt a tangible symbol; or

2. To attach to or logically associate with the record an electronic symbol, sound, or process.

"State" means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

"Technician" means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited, or regulated under federal or state law. The term includes an enucleator.

"Tissue" means a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education.

"Tissue bank" means a person that is licensed, accredited, or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage, or distribution of tissue and that is a member of the Virginia Transplant Council, accredited by the American Association of Tissue Banks, and operating in the Commonwealth of Virginia.

"Transplant hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

2007, cc. 92, 907; 2020, cc. 1227, 1246.

§ 32.1-291.3. Applicability of Act.

This Act applies to an anatomical gift or amendment to, revocation of, or refusal to make an anatomical gift, whenever made.

2007, cc. 92, 907.

§ 32.1-291.4. Who may make anatomical gift before donor's death.

Subject to § 32.1-291.8, an anatomical gift of a donor's body or part may be made during the life of the donor for the purpose of transplantation, therapy, research, or education in the manner provided in § 32.1-291.5 by:

1. The donor, if the donor is an adult or if the donor is a minor and is:

a. Emancipated; or

b. Authorized under state law to apply for a driver's license because the donor is at least 15 years and six months of age;

2. An agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

3. A parent of the donor, if the donor is an unemancipated minor; or

4. The donor's guardian.

2007, cc. 92, 907.

§ 32.1-291.5. Manner of making anatomical gift before donor's death.

A. A donor may make an anatomical gift:

1. By authorizing a statement or symbol indicating that the donor has made an anatomical gift to be imprinted on the donor's driver's license or identification card;

2. In a will;

3. During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults; or

4. As provided in subsection B.

B. A donor or other person authorized to make an anatomical gift under § 32.1-291.4 may make a gift by a donor card or other record signed by the donor or other person making the gift or by authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry. If the donor or other person is physically unable to sign a record, the record may be signed by another individual at the direction of the donor or other person and shall:

1. Be witnessed by at least two adults, who have signed at the request of the donor or the other person; and

2. State that it has been signed and witnessed as provided in subdivision 1.

C. Revocation, suspension, expiration, or cancellation of a driver's license or identification card upon which an anatomical gift is indicated does not invalidate the gift.

D. An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

2007, cc. 92, 907.

§ 32.1-291.6. Amending or revoking anatomical gift before donor's death.

A. Subject to § 32.1-291.8, a donor or other person authorized to make an anatomical gift under § 32.1-291.4 may amend or revoke an anatomical gift by:

1. A record signed by:

a. The donor;

b. The other person; or

c. Subject to subsection B, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or

2. Later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift, either expressly or by inconsistency.

B. A record signed pursuant to subdivision A 1 c shall:

1. Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and

2. State that it has been signed and witnessed as provided in subdivision 1.

C. Subject to § 32.1-291.8, a donor or other person authorized to make an anatomical gift under § 32.1-291.4 may revoke an anatomical gift by the destruction or cancellation of the document of gift, or the portion of the document of gift used to make the gift, with the intent to revoke the gift.

D. A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

E. A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection A.

2007, cc. 92, 907.

§ 32.1-291.7. Refusal to make anatomical gift; effect of refusal.

A. An individual may refuse to make an anatomical gift of the individual's body or part by:

1. A record signed by:

a. The individual; or

b. Subject to subsection B, another individual acting at the direction of the individual if the individual is physically unable to sign;

2. The individual's will, whether or not the will is admitted to probate or invalidated after the individual's death; or

3. Any form of communication made by the individual during the individual's terminal illness or injury addressed to at least two adults, at least one of whom is a disinterested witness.

B. A record signed pursuant to subdivision A 1 b shall:

1. Be witnessed by at least two adults, at least one of whom is a disinterested witness, who have signed at the request of the individual; and

2. State that it has been signed and witnessed as provided in subdivision 1.

C. An individual who has made a refusal may amend or revoke the refusal:

1. In the manner provided in subsection A for making a refusal;

2. By subsequently making an anatomical gift pursuant to § 32.1-291.5 that is inconsistent with the refusal; or

3. By destroying or canceling the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

D. Except as otherwise provided in subsection H of § 32.1-291.8, in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or part bars all other persons from making an anatomical gift of the individual's body or part.

2007, cc. 92, 907.

§ 32.1-291.8. Preclusive effect of anatomical gift, amendment, or revocation.

A. Except as otherwise provided in subsection G and subject to subsection F, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part under § 32.1-291.5 or an amendment to an anatomical gift of the donor's body or part under § 32.1-291.6.

B. A donor's revocation of an anatomical gift of the donor's body or part under § 32.1-291.6 is not a refusal and does not bar another person specified in § 32.1-291.4 or 32.1-291.9 from making an anatomical gift of the donor's body or part under § 32.1-291.5 or 32.1-291.10.

C. If a person other than the donor makes an unrevoked anatomical gift of the donor's body or part under § 32.1-291.5 or an amendment to an anatomical gift of the donor's body or part under § 32.1-291.6, another person may not make, amend, or revoke the gift of the donor's body or part under § 32.1-291.10.

D. A revocation of an anatomical gift of a donor's body or part under § 32.1-291.6 by a person other than the donor does not bar another person from making an anatomical gift of the body or part under § 32.1-291.5 or 32.1-291.10.

E. In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under § 32.1-291.4, an anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person.

F. In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under § 32.1-291.4, an anatomical gift of a part for one or more of the purposes set forth in § 32.1-291.4 is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person under § 32.1-291.5 or 32.1-291.10.

G. If a donor who is an unemancipated minor dies, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

H. If an unemancipated minor who signed a refusal dies, a parent of the minor who is reasonably available may revoke the minor's refusal.

2007, cc. 92, 907.

§ 32.1-291.9. Who may make anatomical gift of decedent's body or part.

A. Subject to subsections B and C and unless barred by § 32.1-291.7 or 32.1-291.8, an anatomical gift of a decedent's body or part for purpose of transplantation, therapy, research, or education may be made by any member of the following classes of persons who is reasonably available, in the order of priority listed:

1. An agent of the decedent at the time of death who could have made an anatomical gift under subdivision 2 of § 32.1-291.4 immediately before the decedent's death;

2. The persons who were acting as the guardians of the person of the decedent at the time of death;

3. The spouse of the decedent;

4. Adult children of the decedent;

5. Parents of the decedent;

6. Adult siblings of the decedent;

7. Adult grandchildren of the decedent;

8. Grandparents of the decedent;

9. An adult who exhibited special care and concern for the decedent; and

10. Any other person having the authority to dispose of the decedent's body.

B. If there is more than one member of a class listed in subdivisions A 1, A 2, A 4, A 5, A 6, A 7, or A 8 entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or a person to which the gift may pass under § 32.1-291.11 knows of an objection by another member of the class. If an objection is known, the gift may be made only by those members who constitute at least 50 percent of the class who are reasonably available.

C. A person may not make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection A is reasonably available to make or to object to the making of an anatomical gift.

2007, cc. 92, 907.

§ 32.1-291.10. Manner of making, amending, or revoking anatomical gift of decedent's body or part.

A. A person authorized to make an anatomical gift under § 32.1-291.9 may make an anatomical gift by a document of gift signed by the person making the gift or by that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

B. Subject to subsection C, an anatomical gift by a person authorized under § 32.1-291.9 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift made by a person authorized under § 32.1-291.9 may be:

1. Amended only if a majority of the reasonably available members agree to the amending of the gift; or

2. Revoked only if a majority of the reasonably available members agree to the revoking of the gift.

C. A revocation under subsection B is effective only if, before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient, the procurement organization, transplant hospital, or physician or technician knows of the revocation.

2007, cc. 92, 907.

§ 32.1-291.11. Persons that may receive anatomical gift; purpose of anatomical gift.

A. An anatomical gift may be made to the following persons named in the document of gift:

1. A hospital; accredited medical school, dental school, or institution of higher education; organ procurement organization; or other appropriate person authorized by the Virginia Transplant Council, for research or education;

2. Subject to subsection B, an individual designated by the person making the anatomical gift if the individual is the recipient of the part; or

3. An eye bank or tissue bank.

B. If an anatomical gift to an individual under subdivision A 2 cannot be transplanted into the individual, the part passes in accordance with subsection G in the absence of an express, contrary indication by the person making the anatomical gift.

C. If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in subsection A but identifies the purpose for which an anatomical gift may be used, the following rules apply:

1. If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.

2. If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.

3. If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.

4. If the part is an organ, an eye, or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

D. For the purpose of subsection C, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift shall be used for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

E. If an anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in subsection A and does not identify the purpose of the gift, the gift may be used for transplantation, therapy, research and education, and the gift passes in accordance with subsection G. The gift shall be used first for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

F. If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor," or "body donor," or by a symbol or statement of similar import, the gift may be used for transplantation, therapy, research and education and the gift passes in accordance with subsection G. The gift shall be used first for transplantation or therapy, if suitable. If the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

G. For purposes of subsections B, E, and F the following rules apply:

1. If the part is an eye, the gift passes to the appropriate eye bank.

2. If the part is tissue, the gift passes to the appropriate tissue bank.

3. If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

H. An anatomical gift of an organ for transplantation, therapy, research or education other than an anatomical gift under subdivision A 2, passes to the organ procurement organization as custodian of the organ.

I. If an anatomical gift does not pass pursuant to subsections A through H or the decedent's body or part is not used for transplantation, therapy, research, or education, custody of the body or part passes to the surviving spouse, next of kin or other person under obligation to dispose of the body or part.

J. A person may not accept an anatomical gift if the person knows that the gift was not effectively made under § 32.1-291.5 or 32.1-291.10 or if the person knows that the decedent made a refusal under § 32.1-291.7 that was not revoked. For purposes of this subsection, if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

K. Except as otherwise provided in subdivision A 2, nothing in this Act affects the allocation of organs for transplantation therapy, research or education.

2007, cc. 92, 907.

§ 32.1-291.12. Search and notification.

A. The following persons shall make a reasonable search of an individual who the person reasonably believes is dead or whose death is imminent for a document of gift or other information identifying the individual as a donor or as an individual who made a refusal:

1. A law-enforcement officer, a firefighter, emergency medical services personnel, or other emergency rescuer finding the individual; and

2. If no other source of the information is immediately available, a hospital, as soon as practical after the individual's arrival at the hospital.

B. If a document of gift or a refusal to make an anatomical gift is located by the search required by subdivision A 1 and the individual or deceased individual to whom it relates is taken to a hospital, the person responsible for conducting the search shall send the document of gift or refusal to the hospital.

C. A person is not subject to criminal or civil liability for failing to discharge the duties imposed by this section but may be subject to administrative sanctions.

2007, cc. 92, 907; 2015, cc. 502, 503.

§ 32.1-291.13. Delivery of document of gift not required; right to examine.

A. A document of gift need not be delivered during the donor's lifetime to be effective.

B. Upon or after an individual's death, a person in possession of a document of gift or a refusal to make an anatomical gift with respect to the individual shall allow examination and copying of the document of gift or refusal by a person authorized to make or object to the making of an anatomical gift with respect to the individual or by a person to which the gift could pass under § 32.1-291.11.

2007, cc. 92, 907.

§ 32.1-291.14. Rights and duties of procurement organization and others.

A. When a hospital refers an individual who is dead or whose death is imminent to a procurement organization, the organization shall make a reasonable search of the records of the Virginia Department of Motor Vehicles and any donor registry that it knows exists for the geographical area in which the individual resides to ascertain whether the individual has made an anatomical gift.

B. A procurement organization shall be allowed reasonable access to information in the records of the Virginia Department of Motor Vehicles to ascertain whether an individual who is dead or whose death is imminent is a donor.

C. When a hospital refers an individual who is dead or whose death is imminent to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of a part that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.

D. Unless prohibited by law other than this Act, at any time after a donor's death, the person to which a part passes under § 32.1-291.11 may conduct any reasonable examination necessary to ensure the medical suitability of the body or part for its intended purpose.

E. Unless prohibited by law other than this Act, an examination under subsection C or D may include an examination of all medical and dental records of the donor or prospective donor.

F. Upon the death of a minor who was a donor or had signed a refusal, unless a procurement organization knows the minor is emancipated, the procurement organization shall conduct a reasonable search for the parents of the minor and provide the parents with an opportunity to revoke or amend the anatomical gift or revoke the refusal.

G. Upon referral by a hospital under subsection A, a procurement organization shall make a reasonable search for any person listed in § 32.1-291.9 having priority to make an anatomical gift on behalf of a prospective donor. If a procurement organization receives information that an anatomical gift to any other person was made, amended, or revoked, it shall promptly advise the other person of all relevant information.

H. Subject to subsection I of § 32.1-291.11 and § 32.1-291.23, the rights of the person to which a part passes under § 32.1-291.11 are superior to the rights of all others with respect to the part. The person may accept or reject an anatomical gift in whole or in part. Subject to the terms of the document of gift and this Act, a person that accepts an anatomical gift of an entire body may allow embalming, burial or cremation, and use of remains in a funeral service. If the gift is of a part, the person to which the part passes under § 32.1-291.11, upon the death of the donor and before embalming, burial, or cremation, shall cause the part to be removed without unnecessary mutilation.

I. Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.

J. A donated part from the body of a donor may be removed only by a physician or technician. The physician or technician performing the removal shall be qualified to remove the donated part from the body. For the purposes of this section, "qualified" means:

1. If the part is an organ, a physician or technician who is authorized by the appropriate organ procurement organization;

2. If the part is an eye, a physician or technician who is approved by an eye bank as qualified to perform the act of eye recovery; or

3. If the part is tissue, any physician or technician who is approved by LifeNet as qualified to perform the act of tissue recovery.

An organ procurement organization may screen, test, and recover eyes and tissue on behalf of an eye bank or tissue bank. Any person authorized by this subsection to recover organs, tissues or eyes may draw blood from the donor and order such tests as may be appropriate to protect his health and the health of the recipients of the organs, tissues or eyes.

2007, cc. 92, 907.

§ 32.1-291.15. Coordination of procurement and use.

Each hospital in this state shall enter into agreements or affiliations with procurement organizations for coordination of procurement and use of anatomical gifts.

2007, cc. 92, 907.

§ 32.1-291.16. Sale or purchase of parts prohibited; penalty.

A. With the exception of hair, ova, blood, and other self-replicating body fluids, it shall be unlawful for any person to sell, to offer to sell, to buy, to offer to buy, or to procure through purchase any natural body part for any reason including, but not limited to, medical and scientific uses such as transplantation, implantation, infusion, or injection. Any person engaging in any of these prohibited activities shall be guilty of a Class 4 felony.

B. Nothing in this section shall prohibit the reimbursement of reasonable expenses associated with the removal, processing, preservation, quality control, storage, transportation, implantation, or disposal of a part.

C. This section shall not be construed to prohibit the donation of any organs, tissues, or any natural body part, knowing that the donor is, or was, infected with a sexually transmitted infection, for use in medical or scientific research.

D. Notwithstanding the provisions of subsection A, this section shall not prohibit the donation or acquisition of organs for transplantation, provided that (i) the recipient of such organ is informed that such organ is infected with human immunodeficiency virus and, following such notice, consents to the receipt of such organ and (ii) acquisition and transplantation of such organ is in compliance with the provisions of the federal HIV Organ Policy Equity Act, 42 U.S.C. § 274f-5.

2007, cc. 92, 907; 2021, Sp. Sess. I, c. 465.

§ 32.1-291.17. Falsification, etc. of document of gift; penalty.

A person that, in order to obtain a financial gain, intentionally falsifies, forges, conceals, defaces, or obliterates a document of gift, an amendment or revocation of a document of gift, or a refusal is guilty of a Class 4 felony.

2007, cc. 92, 907.

§ 32.1-291.18. Immunity.

A. A person that acts in accordance with this Act or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administrative proceeding.

B. Neither the person making an anatomical gift nor the donor's estate is liable for any injury or damage that results from the making or use of the gift.

C. In determining whether an anatomical gift has been made, amended, or revoked under this Act, a person may rely upon representations of an individual listed in subdivisions A 3, A 4, A 5, A 6, A 7, A 8, or A 9 of § 32.1-291.9 relating to the individual's relationship to the donor or prospective donor unless the person knows that the representation is untrue.

2007, cc. 92, 907.

§ 32.1-291.19. Law governing validity; choice of law as to execution of document of gift; presumption of validity.

A. A document of gift is valid if executed in accordance with:

1. This Act;

2. The laws of the state or country where it was executed; or

3. The laws of the state or country where the person making the anatomical gift was domiciled, has a place of residence, or was a national at the time the document of gift was executed.

B. If a document of gift is valid under this section, the law of this state governs the interpretation of the document of gift.

C. A person may presume that a document of gift or amendment of an anatomical gift is valid unless that person knows that it was not validly executed or was revoked.

2007, cc. 92, 907.

§ 32.1-291.20. Donor registry.

For the purposes of this Act, the donor registry is the Virginia Donor Registry established under § 32.1-292.2.

2007, cc. 92, 907.

§ 32.1-291.21. Effect of anatomical gift on advance health-care directive.

A. In this section:

"Advance health-care directive" means an advance directive executed by a prospective donor as provided in the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Declaration" means a record signed by a prospective donor specifying the circumstances under which a life support system may be withheld or withdrawn from the prospective donor.

"Health care decision" means any decision regarding the health care of the prospective donor.

B. If a prospective donor has a declaration or an advance health-care directive and the terms of the declaration or directive and the express or implied terms of a potential anatomical gift are in conflict with regard to the administration of measures necessary to ensure the medical suitability of a part for transplantation or therapy, the prospective donor's attending physician and the prospective donor shall confer to resolve the conflict. If the prospective donor is incapable of resolving the conflict, an agent acting under the prospective donor's declaration or directive, or, if there is no declaration or directive, or the agent is not reasonably available, another person authorized by law other than this Act, to make health care decisions on behalf of the prospective donor, shall act for the donor to resolve the conflict. The conflict shall be resolved as expeditiously as possible. Information relevant to the resolution of the conflict may be obtained from the appropriate procurement organization and any other person authorized to make an anatomical gift for the prospective donor under § 32.1-291.9. Before resolution of the conflict, measures necessary to ensure the medical suitability of an organ for

transplantation or therapy may not be withheld or withdrawn from the prospective donor if withholding or withdrawing the measures is not contraindicated by appropriate end-of-life care.

2007, cc. 92, 907; 2008, c. 82.

§ 32.1-291.22. Cooperation between Office of the Chief Medical Examiner and procurement organization.

A. The Office of the Chief Medical Examiner and procurement organizations shall cooperate with each other to maximize the opportunity to recover anatomical gifts for the purpose of transplantation, therapy, research, or education.

B. If the Office of the Chief Medical Examiner receives notice from a procurement organization that an anatomical gift might be available or was made with respect to a decedent whose body is under the jurisdiction of the Office of the Chief Medical Examiner and a postmortem examination is going to be performed, unless the Chief Medical Examiner or an Assistant Chief Medical Examiner denies recovery in accordance with § 32.1-291.23, the Office of the Chief Medical Examiner shall, when practicable, cause a postmortem examination of the body or the part to be conducted in a manner and within a period compatible with its preservation for the purposes of the gift.

C. A part may not be removed from the body of a decedent under the jurisdiction of the Office of the Chief Medical Examiner for transplantation, therapy, research, or education unless the part is the subject of an anatomical gift. The body of a decedent under the jurisdiction of the Office of the Chief Medical Examiner may not be delivered to a person for research or education unless the body is the subject of an anatomical gift. This subsection does not preclude the Chief Medical Examiner or an Assistant Chief Medical Examiner from performing the medicolegal autopsy upon the body or parts of a decedent under the jurisdiction of the Office of the Chief Medical Examiner or from using the body or parts of a decedent under the jurisdiction of the Office of the Chief Medical Examiner for the purposes of education, training, and research.

2007, cc. 92, 907; 2014, c. 583.

§ 32.1-291.23. Facilitation of anatomical gift from decedent whose body is under jurisdiction of the Office of the Chief Medical Examiner.

A. Upon request of a procurement organization, the Office of the Chief Medical Examiner shall release to the procurement organization the name, contact information, and available medical and social history of a decedent whose body is under the jurisdiction of the Office of the Chief Medical Examiner. If the decedent's body or part is medically suitable for transplantation, therapy, research, or education, the Office of the Chief Medical Examiner shall release postmortem examination results to the procurement organization. The procurement organization may make a subsequent disclosure of the postmortem examination results or other information received from the Office of the Chief Medical Examiner only if relevant to transplantation, therapy, research, or education.

B. The Office of the Chief Medical Examiner may conduct a medicolegal investigation by reviewing all medical records, laboratory test results, x-rays, other diagnostic results, and other information that any

person possesses about a donor or prospective donor whose body is under the jurisdiction of the Office of the Chief Medical Examiner.

C. A person that has any information requested by the Office of the Chief Medical Examiner pursuant to subsection B shall provide that information as expeditiously as possible to allow the Office of the Chief Medical Examiner to conduct the medicolegal investigation within a period compatible with the preservation of parts for the purpose of transplantation, therapy, research, or education.

D. If an anatomical gift has been or might be made of a part of a decedent whose body is under the jurisdiction of the Office of the Chief Medical Examiner and a postmortem examination is not required, or the Office of the Chief Medical Examiner determines that a postmortem examination is required but that the recovery of the part that is the subject of an anatomical gift will not interfere with the examination, the Office of the Chief Medical Examiner and procurement organization shall cooperate in the timely removal of the part from the decedent for the purpose of transplantation, therapy, research, or education.

E. The Office of the Chief Medical Examiner and procurement organizations shall enter into an agreement setting forth protocols and procedures to govern relations between the parties when an anatomical gift of a part from a decedent under the jurisdiction of the Office of the Chief Medical Examiner has been or might be made, but the Office of the Chief Medical Examiner believes that the recovery of the part could interfere with the postmortem investigation into the decedent's cause or manner of death. Decisions regarding the recovery of organs, tissue and eyes from such a decedent shall be made in accordance with the agreement. In the event that an Assistant Chief Medical Examiner denies recovery of an anatomical gift, the procurement organization may request the Chief Medical Examiner to reconsider the denial and to permit the recovery to proceed. The parties shall evaluate the effectiveness of the protocols and procedures at regular intervals but no less frequently than every two years.

F. If the Office of the Chief Medical Examiner allows recovery of a part under subsection D or E, the procurement organization, upon request, shall cause the physician or technician who removes the part to provide the Office of the Chief Medical Examiner with a record describing the condition of the part, a biopsy, a photograph, and any other information and observations that would assist in the postmortem examination.

G. If the Office of the Chief Medical Examiner is required to be present at a removal procedure under subsection E, upon request the procurement organization requesting the recovery of the part shall reimburse the Office of the Chief Medical Examiner for the additional costs incurred in complying with subsection E.

2007, cc. 92, 907; 2014, c. 583.

§ 32.1-291.24. Uniformity of application and construction.

In applying and construing this uniform act, consideration shall be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

2007, cc. 92, 907.

§ 32.1-291.25. Relation to Electronic Signatures in Global and National Commerce Act.

This Act modifies, limits, and supersedes the Electronic Signatures in Global and National Commerce Act, 15 U.S.C. § 7001 et seq., but does not modify, limit or supersede § 101(a) of that act, 15 U.S.C. § 7001, or authorize electronic delivery of any of the notices described in § 103(b) of that act, 15 U.S.C. § 7003(b).

2007, cc. 92, 907.

§ 32.1-292. Repealed.

Repealed by Acts 1990, c. 959.

§ 32.1-292.1. Repealed.

Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-292.2. The Virginia Donor Registry.

A. In order to save lives by reducing the shortage of organs and tissues for transplantation and to implement cost savings for patients and various state agencies by eliminating needless bureaucracy, there is hereby established the Virginia Donor Registry (hereinafter referred to as the Registry), which shall be created, compiled, operated, maintained, and modified as necessary by the Virginia Transplant Council in accordance with the regulations of the Board of Health and the administration of the Department of Health. At its sole discretion, the Virginia Transplant Council may contract with a third party or parties to create, compile, operate, maintain or modify the Registry. Pertinent information on all Virginians who have indicated a willingness to donate organs and tissues in accordance with the Revised Uniform Anatomical Gift Act (§ 32.1-291.1 et seq.) shall be compiled, maintained, and modified as necessary in the Registry by the Virginia Transplant Council.

B. The Registry and all information therein shall be confidential and subject to access only by personnel of the Department of Health and designated organ procurement organizations, eye banks, and tissue banks, operating in or serving Virginia that are members of the Virginia Transplant Council, for the purpose of identifying and determining the suitability of a potential donor according to the provisions of subdivision B 4 of § 32.1-127 or subsection G of § 46.2-342.

C. The purpose of the Registry shall include, but not be limited to:

1. Providing a means of recovering an anatomical gift for transplantation, therapy, education or research as authorized by the Revised Uniform Anatomical Gift Act (§ 32.1-291.1 et seq.) and subsection G of § 46.2-342; and

2. Collecting data to develop and evaluate the effectiveness of educational initiatives promoting organ, eye, and tissue donation that are conducted or coordinated by the Virginia Transplant Council or its members.

D. The Board, in consultation with the Virginia Transplant Council, shall promulgate regulations necessary to create, compile, operate, maintain, modify as necessary, and administer the Virginia Donor Registry. The regulations shall include, but not be limited to:

1. Recording the data subject's full name, address, sex, birth date, age, driver's license number or unique identifying number, and other pertinent identifying personal information;

2. Authorizing the Virginia Transplant Council to analyze Registry data under research protocols that are designed to identify and assess the effectiveness of mechanisms to promote and increase organ, eye, and tissue donation within the Commonwealth; and

3. Providing that any Virginian whose name has been placed in the registry may have his name deleted by filing an appropriate form with the Virginia Transplant Council or in accordance with the Revised Uniform Anatomical Gift Act (§ 32.1-291.1 et seq.).

2000, cc. 481, 490; 2006, c. 166; 2007, cc. 92, 907; 2008, c. 82; 2009, c. 834; 2010, cc. 25, 55; 2016, cc. 135, 743.

§ 32.1-293. Repealed.

Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-294. Repealed.

Repealed by Acts 1990, c. 959.

§ 32.1-295. Repealed.

Repealed by Acts 2007, cc. 92 and 907, cl. 2.

§ 32.1-296. Determination of death.

The provisions of § 54.1-2972 shall be applicable for the purposes of this article.

1979, c. 711.

§ 32.1-297. Action for implied warranty in connection with transfer of blood or human tissue.

No action for implied warranty shall lie for the procurement, processing, distribution or use of whole blood, plasma, blood products, blood derivatives and other human tissue such as corneas, bones, or organs for the purpose of injecting, transfusing or transplanting any of them into the human body except where any defects or impurities in the said whole blood, plasma, blood products, blood derivatives and other human tissue such as corneas, bones, or organs are detectable by the use of established medical and technological procedures employed pursuant to the standards of local medical practice.

Code 1950, § 32-364.2; 1968, c. 81; 1979, c. 711.

§ 32.1-297.1. The Virginia Transplant Council.

A. The Virginia Transplant Council (hereinafter referred to as the Council) is hereby established to fulfill the following duties:

1. To create, compile, maintain, and modify as necessary the Virginia Donor Registry established in § 32.1-292.2 in accordance with the regulations of the Board of Health and the administration of the Department of Health;

2. To conduct public education and information services relating to organ, tissue, and eye donation in the Commonwealth;

3. To coordinate organ, tissue, and eye donation activities in the Commonwealth;

4. To provide a forum for discussion among its members of any issues of which it may be apprised that could impact the effectiveness of its activities and the relationship between the public and its members; and

5. To advise the Board and Department of Health concerning organ, tissue, and eye donation activities, procurement, and transplantation efforts in Virginia.

The Council shall establish such bylaws as may be necessary for its operation, consistent with state and federal law.

B. The membership of the Council shall consist of the following organizations, each of whom shall have one vote: INOVA Fairfax Hospital, Henrico Doctors' Hospital, LifeNet Health, Lion's Medical Eye Bank and Research Center of Eastern Virginia, Mountain Regional Donor Services, Old Dominion Eye Foundation, Inc., Sentara Norfolk General Hospital, University of Virginia Health System, Virginia Commonwealth University Health System, Washington Regional Transplant Community, Children's Hospital of The King's Daughters, and any successor organization thereof that remains directly involved in activities related to organ, tissue, or eye donation, procurement, or transplantation in Virginia, and one representative of donor families and one representative of transplant recipients. The Council shall elect, from among its membership, such officers as its bylaws require to serve for the terms established in such bylaws.

The Council shall also elect the representatives of donor families and transplant recipients who shall serve for terms established in the bylaws.

C. In order to provide flexibility and coordination and to prevent duplication of efforts, the Council may agree to extend nonvoting, associate membership on the Council to representatives of other organizations, agencies, or experts, public or private, who (i) are directly involved in or (ii) provide education or information on organ, tissue, or eye donation, procurement, or transplantation. Such membership (a) shall be extended to the Virginia Departments of Education, Health, Health Professions, and Motor Vehicles, and the Virginia Hospital and Healthcare Association; (b) may include at least one representative of the faith community and one representative of local public schools; and (c) may be extended to other organizations, agencies, or experts as the Council deems appropriate.

D. In addition to the duties assigned in subsection A, the Council (i) shall inform the Board regarding the Council's activities; (ii) shall conduct and coordinate professional education and informational activities as they relate to organ, tissue, and eye donation, procurement, and transplantation efforts;

and (iii) as appropriate, may conduct its activities in coordination with other organizations whose goals are related to organ, tissue, or eye donation, procurement, or transplantation. To achieve its purposes efficiently and effectively, the Council may conduct its activities in partnership with its member organizations or may contract for services with appropriate parties.

E. The Council, or the Board on behalf of the Council, may apply for, accept, and expend gifts, grants, or donations from public or private sources to enable the Council to further its purposes and carry out its duties, and the Council may comply with such conditions and requirements as may be imposed on it in connection therewith.

There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Donor Registry and Public Awareness Fund (the Fund). The Fund shall be established on the books of the Comptroller as a revolving fund and shall consist of such gifts, grants, or donations as may be received pursuant to this subsection and any moneys appropriated by the General Assembly to support the Council's education and information programs. Moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Interest earned on such funds shall remain in the Fund and be credited to it. The Council shall administer funds made available to it from the Fund and shall disburse such funds in accordance with the purposes of this article.

F. The Council may employ such employees, permanent and temporary, as it may deem necessary for the proper performance of its duties and shall determine their qualifications and duties. Employees of the Council shall be compensated in the manner provided by the Council and shall not be subject to the provisions of the Virginia Personnel Act (§ 2.2-2900 et seq.). Actual expenses incurred by the members of the Council in the performance of their duties and actual costs of hiring and compensating employees of the Council shall be paid from the Virginia Donor Registry and Public Awareness Fund.

G. In addition to such other reports as may be required by the Commissioner or the Board, on or before September 30 of each year, the Council shall submit a report on its activities, programs, and funding in the previous fiscal year to the Board.

1985, c. 412; 1990, c. 336; 1991, c. 37; 1997, c. 799; 2002, c. 467; 2006, c. 166; 2009, c. 834; 2012, c. 692; 2022, c. 72.

§ 32.1-297.2. Discrimination prohibited.

A. As used in this section:

"Auxiliary aids or services" means an aid or service that is used to provide information to an individual with a cognitive, developmental, intellectual, neurological, or physical disability in a format or manner that allows the individual to better understand the information. "Auxiliary aids or services" includes (i) qualified interpreters or other effective methods of making aurally delivered materials available to persons with hearing impairments; (ii) qualified readers, taped texts, texts in accessible electronic format, or other effective methods of making visually delivered materials available to persons with visual impairments; (iii) supported decision-making services, including (a) use of a support individual to

communicate information to the individual with a disability, ascertain the wishes of the individual, or assist the individual in making decisions; (b) disclosure of information to a legal guardian, authorized representative, or another individual designated by the individual with a disability for such purpose, as long as the disclosure is consistent with state and federal law; and (c) if an individual has a court-appointed guardian or other individual responsible for making medical decisions on behalf of the individual, any measures used to ensure that the individual is included in decisions involving the individual's health care and that medical decisions are made in accordance with the individual's own expressed interests; and (iv) any other aid or service that is used to provide information in a format that is easily understandable and accessible to individuals with cognitive, developmental, intellectual, neurological, or physical disability, including assistive communication technology.

"Covered entity" means any licensed provider of health care services, including any health care practitioner licensed by a health regulatory board of the Department of Health Professions, hospital, nursing facility, laboratory, intermediate care facility, psychiatric residential treatment facility, institution for individuals with intellectual or developmental disabilities, or prison health center, and any entity responsible for matching anatomical gift donors to potential recipients.

"Eligible individual" means an individual who is a candidate to receive an anatomical gift for transplantation and who is otherwise eligible to receive an anatomical gift for transplantation, with or without auxiliary aids and services.

"Eligible individual with a disability" means an eligible individual with a cognitive, developmental, intellectual, neurological, or physical disability.

"Services related to organ, eye, or tissue transplantation" means referral to a transplant center or specialist; inclusion on an organ, eye, or tissue transplantation waiting list; evaluation; surgery and related health care services; counseling; or post-transplantation treatment and services related to organ, eye, or tissue transplantation.

B. An eligible individual shall not be deemed ineligible to receive an anatomical gift or denied services related to organ, eye, or tissue transplantation solely because he is an eligible individual with a disability. However, an eligible individual may be deemed ineligible to receive an anatomical gift or denied services related to organ, eye, or tissue transplantation to the extent that his cognitive, developmental, intellectual, neurological, or physical disability has been determined by a health care provider, following an individualized evaluation, to be medically significant to the provision of the anatomical gift for organ, eye, or tissue transplantation.

C. If an eligible individual with a disability has the necessary support system to assist the individual in complying with post-transplantation medical requirements, his inability to independently comply with such post-transplantation medical requirements shall not be deemed to be medically significant.

D. No covered entity shall (i) place an eligible individual with a disability on an organ transplant waiting list at a position lower in priority than the position at which the eligible individual with a disability would have been placed if he did not have a disability or (ii) refuse insurance coverage for any

services related to organ, eye, or tissue transplantation provided to an eligible individual with a disability.

E. A covered entity shall (i) make reasonable modifications to its policies, practices, or procedures to allow eligible individuals with disabilities access to services related to organ, eye, or tissue transplantation and (ii) take all steps necessary to ensure that an eligible individual with a disability is not denied medical services or services related to organ, eye, or tissue transplantation due to the absence of auxiliary aids or services. A covered entity shall not be required to comply with clause (ii) if the covered entity demonstrates that taking such steps would fundamentally alter the nature of the medical services or other services related to organ, eye, or tissue transplantation or would result in an undue burden for the covered entity.

F. In cases in which a violation of this section is alleged to have occurred, a petition shall be filed in the circuit court for the jurisdiction in which the violation is alleged to have occurred or in which the individual is located. Any petition filed pursuant to this subsection shall be given priority on the docket. Any order of the court entered on such petition may grant injunctive relief, including (i) requiring auxiliary aids or services to be made available to an eligible individual with a disability; (ii) requiring the modification of a policy, practice, or procedure of a covered entity; or (iii) requiring that facilities be made accessible to and usable by an eligible individual with a disability.

G. The provisions of this section shall apply to each part of the anatomical gift and organ, eye, or tissue transplantation process.

H. The provisions of this section shall not be construed to require the provision of medically inappropriate services related to organ, eye, or tissue transplantation.

2020, cc. 217, 218.

Article 3 - USE OF DEAD HUMAN BODIES FOR SCIENTIFIC STUDY

§ 32.1-298. Notification of Commissioner and delivery of bodies.

Any person having charge or control of any dead human body that has been lawfully donated for scientific study shall notify the Commissioner whenever and as soon as any such body comes to his possession, charge, or control and shall, without fee or reward, permit the Commissioner or his agents to remove such body, to be used for the advancement of health science.

Code 1950, § 32-356; 1974, cc. 44, 45; 1979, c. 711; 2014, cc. 228, 583.

§ 32.1-299. Distribution of bodies.

A. The bodies received pursuant to § 32.1-298 shall be distributed by the Commissioner to institutions and individuals as they may be needed for the purposes of scientific education and training in health and related subjects as follows:

1. First, to the medical schools in Virginia;

2. Second, equitably to the several colleges and schools of this Commonwealth authorized by law to teach health science and issue diplomas and such physicians and surgeons as the Commissioner may designate;

3. Third, to colleges and schools in other states and the District of Columbia authorized by law to teach health science and issue diplomas.

B. Before any institution or individual may receive any body pursuant to this section, such institution or individual shall have given a bond to the Commonwealth in the penalty of $1,000 with condition that any body received shall be used only for scientific education and training in health and related subjects. Evidence of such bond shall be filed with the Commissioner.

C. All expenses incurred in the distribution and delivery of bodies pursuant to this section shall be paid by those receiving the bodies in such amount as may be prescribed by the Commissioner.

D. The Commissioner is authorized to employ carriers to effect the distribution of dead human bodies pursuant to this section. Any carrier so employed shall obtain a receipt by name or, if the name be unknown, by a description for each body delivered by him and shall deposit such receipt with the Commissioner.

Code 1950, §§ 32-357, 32-358, 32-360, 32-363; 1976, c. 222; 1979, c. 711; 2014, c. 228.

§ 32.1-300. Records of bodies distributed.

The Commissioner shall keep a record of all bodies received and distributed, together with data pertaining to the disposition thereof.

Code 1950, § 32-355; 1979, c. 711.

§ 32.1-301. Burial, cremation, or return of bodies after scientific study.

After the bodies distributed pursuant to § 32.1-299 have been used for the purpose of instruction, they shall be decently interred or cremated by the institution or individual receiving them. However, if the decedent has stipulated in writing before his death that the cremated remains of his body, lawfully donated for scientific study, shall be returned to relatives for disposition after scientific study has been completed, or if the decedent's next of kin, who lawfully donated the body for scientific study, requests in writing at the time of donation that the decedent's cremated remains be returned to relatives after scientific study has been completed, the institution or individual that received the body shall return the decedent's cremated remains to his next of kin or relatives. Any such writing shall acknowledge the responsibility to maintain the current name, address, and telephone number of the relatives to whom the decedent's cremated remains are to be returned.

The written request of the decedent's next of kin shall include the name of the next of kin, the current address to which the cremated remains shall be delivered, and the current telephone number of the next of kin or relatives where they may be contacted. The costs of transporting and delivering the cremated remains shall be borne by the institution or individual receiving the body. The institution or individual that received the decedent's body and who has received such a written request shall not be

obligated to return the decedent's cremated remains if the name, address, and telephone number of the next of kin or relatives have not been provided in such written request or are no longer current.

Code 1950, § 32-359; 1979, c. 711; 2000, c. 477; 2014, c. 583.

§ 32.1-302. Importation of anatomical material.

The Commissioner may, in his discretion, on the application of any person, empower such person to import into this Commonwealth and traffic in such anatomical material and pathological specimens as the Commissioner may designate.

Code 1950, § 32-362; 1979, c. 711.

§ 32.1-303. Penalty for trafficking in bodies.

Except as provided in §§ 32.1-299 and 32.1-302, if any person sell or buy any dead human body, or in any way traffic in the same, or transmit or convey, or procure in order to be transmitted or conveyed, any such body for the purpose of trafficking in the same to any place outside of this Commonwealth, he shall be guilty of a Class 1 misdemeanor.

Code 1950, § 32-361; 1976, c. 222; 1979, c. 711.

§ 32.1-304. General penalty for violation.

If any person fail or refuse to perform any duty imposed upon him by this article, he shall, unless otherwise provided, be guilty of a Class 3 misdemeanor.

Code 1950, § 32-364; 1979, c. 711.

Article 4 - CREMATION

§§ 32.1-305 through 32.1-309. Repealed.

Repealed by Acts 1998, c. 867.

Chapter 8.1 - DISPOSITION OF DEAD HUMAN BODIES

§ 32.1-309.1. Identification of decedent, next of kin; disposition of claimed dead body.

A. As used in this chapter, unless the context requires a different meaning:

"Disposition" means the burial, interment, entombment, cremation, or other authorized disposition of a dead body permitted by law.

"Next of kin" has the same meaning assigned to it in § 54.1-2800.

B. In the absence of a next of kin, a person designated to make arrangements for disposition of the decedent's remains pursuant to § 54.1-2825, an agent named in an advance directive pursuant to § 54.1-2984, or any guardian appointed pursuant to Chapter 20 (§ 64.2-2000 et seq.) of Title 64.2 who may exercise the powers conferred in the order of appointment or by § 64.2-2019, or upon the failure or refusal of such next of kin, designated person, agent, or guardian to accept responsibility for the disposition of the decedent, then any other person 18 years of age or older who is able to provide positive identification of the deceased and is willing to pay for the costs associated with the disposition of

the decedent's remains shall be authorized to make arrangements for such disposition of the decedent's remains. If a funeral service establishment or funeral service licensee makes arrangements with a person other than a next of kin, designated person, agent, or guardian in accordance with this section, then the funeral service licensee or funeral service establishment shall be immune from civil liability unless such act, decision, or omission resulted from bad faith or malicious intent.

C. Upon the death of any person, irrespective of the cause and manner of death, and irrespective of whether a medical examiner's investigation is required pursuant to § 32.1-283 or 32.1-285.1, the person or institution having initial custody of the dead body shall make good faith efforts to determine the identity of the decedent, if unknown, and to identify and notify the next of kin of the decedent regarding the decedent's death. If, upon notification of the death of the decedent, the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains is willing and able to claim the body, the body may be claimed by the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains for disposition, and the claimant shall bear the expenses of such disposition. If the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains fails or refuses to claim the body within 10 days of receiving notice of the death of the decedent, the body shall be disposed of in accordance with § 32.1-309.2.

D. If the person or institution having initial custody of the dead body is unable to determine the identity of the decedent or to identify and notify the next of kin of the decedent regarding the decedent's death, the person or institution shall contact the primary law-enforcement agency for the locality in which the person or institution is located, which shall make good faith efforts to determine the identity of the decedent and to identify and notify the next of kin of the decedent. However, in cases in which the identity of the decedent and the county or city in which the decedent resided at the time of death are known, the person or institution having initial custody of the dead body shall notify the primary law-enforcement agency for the county or city in which the decedent resided regarding the decedent's death, and the law-enforcement agency for the county or city in which the decedent resided shall make good faith efforts to identify and notify the next of kin of the decedent.

If the identity of the decedent is known to the primary law-enforcement agency or the primary law-enforcement agency is able to identify the decedent, the primary law-enforcement agency is able to identify and notify the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains, and the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains is willing and able to claim the body, the body may be claimed by the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains for disposition, and the claimant shall bear the expenses of such disposition.

If the identity of the decedent is known or the primary law-enforcement agency is able to determine the identity of the decedent but the primary law-enforcement agency is unable, despite good faith efforts, to identify and notify the decedent's next of kin or other person authorized by law to make

arrangements for disposition of the decedent's remains within 10 days of the date of contact by the person or institution having initial custody of the dead body, or the primary law-enforcement agency is able to identify and notify the decedent's next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains but the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains fails or refuses to claim the body within 10 days, the primary law-enforcement agency shall notify the person or institution having initial custody of the dead body, and the body shall be disposed of in accordance with § 32.1-309.2.

E. In cases in which a dead body is claimed by the decedent's next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains but the next of kin or other person authorized by law to make arrangements for disposition of the decedent's remains is unable to pay the reasonable costs of disposition of the body and the costs are paid by the county or city in which the decedent resided or in which the death occurred in accordance with this section, and the decedent has an estate out of which disposition expenses may be paid, in whole or in part, such assets shall be seized for such purpose.

F. No dead body that is the subject of an investigation pursuant to § 32.1-283 or autopsy pursuant to § 32.1-285 shall be transferred for purposes of disposition until such investigation or autopsy has been completed.

G. Any sheriff or primary law-enforcement officer, county, city, health care provider, funeral service establishment, funeral service licensee, or other person or institution that acts in accordance with the requirements of this chapter shall be immune from civil liability for any act, decision, or omission resulting from acceptance and disposition of the dead body in accordance with this section, unless such act, decision, or omission resulted from bad faith or malicious intent.

H. Nothing in this section shall prevent a law-enforcement agency other than the primary law-enforcement agency from performing the duties established by this section if so requested by the primary law-enforcement agency and agreed to by the other law-enforcement agency.

2014, c. 228; 2015, cc. 658, 670.

§ 32.1-309.2. Disposition of unclaimed dead body; how expenses paid.

A. In any case in which (i) the primary law-enforcement agency of the county or city in which the person or institution having initial custody of the dead body of the decedent is located or the county or city in which the decedent resided, as may be appropriate pursuant to § 32.1-309.1, is unable to identify and notify the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains within 10 days of the date of contact by the person or institution having initial custody of the dead body despite good faith efforts to do so or (ii) the next of kin of the decedent or other person authorized by law to make arrangements for disposition of the decedent's remains fails or refuses to claim the body within 10 days of receipt of notice of the decedent's death, the primary law-enforcement agency shall notify (a) the attorney for the county or city in which the decedent resided at the time of death, if known, or (b) if the decedent's county or city of residence at

the time of death is not known, the attorney for the county or city in which the person or institution having initial custody of the dead body is located or, if there is no county or city attorney, the attorney for the Commonwealth in such county or city, and such attorney shall forthwith and without delay request an order to be entered by the court within one business day of receiving such request authorizing the person or institution having initial custody of the dead body to transfer custody of the body to a funeral service establishment for final disposition. Such request shall contain transportation and disposition instructions for the unclaimed dead body. Upon entry of a final order for disposition of the dead body, the person or institution having initial custody of the body shall transfer custody of the body to a funeral service establishment, which shall take possession of the dead body for disposition in accordance with the provisions of such order. In such final order, the court may direct the clerk to forthwith provide a copy of the final order to the attorney who has submitted the request for a final order authorizing the person or institution having initial custody of the dead body to transfer custody of the dead body to a funeral service establishment for final disposition in accordance with this subsection. Except as provided in subsection B or C, the reasonable expenses of disposition of the body shall be borne (1) by the county or city in which the decedent resided at the time of death if the decedent was a resident of Virginia or (2) by the county or city where death occurred if the decedent was not a resident of Virginia or the location of the decedent's residence cannot reasonably be determined. However, no such expenses shall be paid by such county or city until allowed by an appropriate court in such county or city.

B. In the case of a person who has been received into the state corrections system and died prior to his release, whose body is unclaimed, the Department of Corrections shall accept the body for proper disposition and shall bear the reasonable expenses for cremation or other disposition of the body. In the case of a person who has been received into the state corrections system and died prior to his release and whose claimant is financially unable to pay reasonable expenses of disposition, the expenses shall be borne by the county or city where the claimant resides.

C. In the case of a person who has been committed to the custody of the Department of Behavioral Health and Developmental Services and died prior to his release, whose body is unclaimed, the Department of Behavioral Health and Developmental Services shall bear the reasonable expenses for cremation or other disposition of the body. In the case of a person who has been committed to the custody of the Department of Behavioral Health and Developmental Services and died prior to his release and whose claimant is financially unable to pay reasonable expenses of disposition, the expenses shall be borne by the county or city where the claimant resides.

D. Any person or institution having initial custody of a dead body may enter into an agreement with a local funeral service establishment whereby the funeral service establishment shall take possession of the dead body for the purpose of storing the dead body during such time as the person or institution having initial custody of the body or the primary local law-enforcement agency is engaged in identifying the decedent, attempting to identify and contact the next of kin of the decedent, and making arrangements for the final disposition of the body in accordance with this section, provided that at all

times during which the funeral service establishment is providing storage of the body, the person or institution having initial custody of the dead body shall continue to have legal custody of the body until such time as custody is transferred in accordance with this chapter.

E. In cases in which a decedent whose remains are disposed of in accordance with this section has an estate out of which disposition expenses may be paid, in whole or in part, or the decedent has any nonprobate assets listed in § 64.2-620 out of which disposition expenses may be paid, such assets shall be seized for such purpose.

F. No dead body that is the subject of an investigation pursuant to § 32.1-283 or autopsy pursuant to § 32.1-285 shall be transferred for purposes of disposition until such investigation or autopsy has been completed.

G. Any sheriff or primary law-enforcement officer, county, city, health care provider, funeral service establishment, or funeral service licensee; the Department of Corrections; or any other person or institution that acts in accordance with the requirements of this chapter shall be immune from civil liability for any act, decision, or omission resulting from acceptance and disposition of the dead body in accordance with this section, unless such act, decision, or omission resulted from bad faith or malicious intent.

H. Nothing in this section shall prevent a law-enforcement agency other than the primary law-enforcement agency from performing the duties established by this section if so requested by the primary law-enforcement agency and agreed to by the other law-enforcement agency.

2014, c. 228; 2015, cc. 658, 670; 2018, c. 773; 2023, c. 486.

§ 32.1-309.3. Cremations and burials at sea.

No dead human body whose death occurred in Virginia shall be cremated or buried at sea, irrespective of the cause and manner of death, unless the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 has determined that there is no further need for medicolegal inquiry into the death and so certifies upon a form supplied by the Office of the Chief Medical Examiner. For this service the Chief Medical Examiner, an Assistant Chief Medical Examiner, or a medical examiner appointed pursuant to § 32.1-282 shall be entitled to a fee established by the Board, not to exceed the fee provided for in subsection D of § 32.1-283, to be paid by the applicant for the certificate.

2014, cc. 228, 583.

§ 32.1-309.4. Determination of hazardous human remains.

The Commissioner, in consultation with the Governor, shall have the authority to determine if human remains are hazardous to the public health. If the Commissioner determines that such remains are hazardous, the Commonwealth, with direction from the Commissioner, shall be charged with the safe handling, identification, and disposition of the remains and shall erect a memorial, as appropriate, at any disposition site.

For the purposes of this section, "hazardous," with regard to human remains, means those remains contaminated with an infectious, radiologic, chemical, or other dangerous agent.

2014, c. 228.

§ 32.1-309.5. Storage of a dead human body.

If a dead human body is to be stored for more than 48 hours prior to disposition, any institution having custody of such body shall ensure that the dead human body is maintained in refrigeration at no more than approximately 40 degrees Fahrenheit or shall enter into an agreement with a local funeral service establishment pursuant to subsection D of § 32.1-309.2. Any related expenses shall be borne by the claimant or the relevant city or county in accordance with § 32.1-309.1 or 32.1-309.2.

2016, c. 411.

Chapter 9 - Regulation of Medical Assistance

Article 1 - IN GENERAL

§ 32.1-310. Declaration of purpose; authority to audit records; authority to review complaints of abuse or neglect.

The General Assembly finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the Commonwealth that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental and other health services to recipients of medical assistance. In order to effectively accomplish such purpose and to assure that the recipient receives such services as are paid for by the Commonwealth, the acceptance by the recipient of such services and the acceptance by practitioners of reimbursement for performing such services shall authorize the Attorney General or his authorized representative to inspect and audit all records in connection with the providing of such services.

The General Assembly further finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the Commonwealth that, in conducting such regulatory and inspection program, the Attorney General or his authorized representatives shall review complaints alleging abuse or neglect of persons in the care or custody of others who receive payments for providing health care services under the state plan for medical assistance.

1981, c. 255; 1982, c. 41; 2011, cc. 110, 175.

§ 32.1-311. Repealed.

Repealed by Acts 1982, c. 41.

§ 32.1-312. Fraudulently obtaining excess or attempting to obtain excess benefits or payments; penalty.

A. No person, agency or institution, but not including an individual medical assistance recipient of health care, on behalf of himself or others, whether under a contract or otherwise, shall obtain or attempt to obtain benefits or payments where the Commonwealth directly or indirectly provides any

portion of the benefits or payments pursuant to the Plan for Medical Assistance and any amendments thereto as provided for in § 32.1-325, hereafter referred to as "medical assistance" in a greater amount than that to which entitled by:

1. Knowingly and willfully making or causing to be made any false statement or false representation of material fact;

2. Knowingly and willfully concealing or causing to be concealed any material facts; or

3. Knowingly and willfully engaging in any fraudulent scheme or device, including, but not limited to, submitting a claim for services, drugs, supplies or equipment that were unfurnished or were of a lower quality, or a substitution or misrepresentation of items billed.

B. Any person, agency or institution knowingly and willfully violating any of the provisions of subsection A shall be (i) liable for repayment of any excess benefits or payments received, plus interest on the amount of the excess benefits or payments at the rate of 1.5 percent each month for the period from the date upon which payment was made to the date upon which repayment is made to the Commonwealth and (ii) in addition to any other penalties provided by law, subject to civil penalties. The state Attorney General may petition the circuit court in the jurisdiction of the alleged offense, to seek an order assessing civil penalties in an amount not to exceed three times the amount of such excess benefits or payments. Such civil penalties shall not apply to any acts or omissions occurring prior to the effective date of this law.

C. A criminal action need not be brought against a person for that person to be civilly liable under this section.

D. Civil penalties shall be deposited in the general fund of the state treasury upon their receipt.

E. A civil action under this section shall be brought (i) within six years of the date on which the violation was committed, or (ii) within three years of the date when an official of the Commonwealth charged with the responsibility to act in the circumstances discovered or reasonably should have discovered the facts material to the cause of action. However, in no event shall the limitations period extend more than 10 years from the date on which the violation was committed.

1981, c. 255; 1984, c. 781; 2007, c. 569; 2010, c. 305.

§ 32.1-313. Liability for excess benefits or payments obtained without intent to violate chapter.

A. Any person, agency or institution, but not including an individual medical assistance recipient of health care, that, without intent to violate this chapter, whether under contract or otherwise, obtains benefits or payments where the Commonwealth directly or indirectly provides any portion of the benefits or payments under medical assistance to which such person, agency or institution is not entitled, or in a greater amount than that to which entitled, shall be liable for (i) any excess benefits or payments received, and (ii) interest on the amount of the excess benefits or payments at the judgment rate as defined in § 6.2-302 from the date upon which such person, agency, or institution knew or reasonably should have known that it had received excess benefits or payments to the date upon which

repayment is made to the Commonwealth. No person, agency or institution shall be liable for payment of interest, however, when excess benefits or payments were obtained as a result of errors made solely by the Department of Medical Assistance Services. Whenever a penalty or interest is due under this section or § 32.1-312, such penalty or interest shall not be reimbursable by the Commonwealth as an allowable cost under any of the provisions of this chapter.

B. A civil action under this section shall be brought (i) within six years of the date on which the violation was committed, or (ii) within three years of the date when an official of the Commonwealth charged with the responsibility to act in the circumstances discovered or reasonably should have discovered the facts material to the cause of action. However, in no event shall the limitations period extend more than 10 years from the date on which the violation was committed.

1981, c. 255; 1986, c. 551; 2007, c. 569.

§ 32.1-314. False statement or representation in applications for payment or for use in determining rights to payment; concealment of facts; penalty.

A. Any person who engages in the following activities shall be guilty of a felony punishable by a term of imprisonment of not less than one nor more than 20 years, or in the discretion of the jury or the court trying the case without a jury, confinement in jail for not more than 12 months and, in addition to such imprisonment or confinement, may be fined an amount not to exceed $25,000:

1. Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application for any payment under medical assistance;

2. At any time knowingly and willfully making or causing to be made any false statement or representation of a material fact for use in determining rights to such payment, or knowingly and willfully falsifying, concealing or covering up by any trick, scheme or device a material fact, causing a material fact to be falsified, concealed, or covered up in such a manner in connection with such application or payment; or

3. When having knowledge of the occurrence of any event affecting (i) the initial or continued right to any payment or (ii) the initial or continued right to any such payment of any other individual in whose behalf he has applied for or is receiving such payments, willfully concealing or failing to disclose such event, causing such concealment or failure to disclose such an event with an intent fraudulently to secure such payment either in a greater amount or quantity than is due or when no such payment is authorized.

B. Upon conviction for any violation of subsection A, the court shall order restitution to be made to the Department of Medical Assistance Services for any loss caused by the violation.

C. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

D. Venue for the trial of any person charged with an offense under this section shall be the county or city in which (i) any act was performed in furtherance of the offense or (ii) the person charged with the offense resided at the time of the offense.

1981, c. 255; 1986, c. 551; 1995, c. 491; 2010, c. 305; 2011, cc. 444, 479; 2015, c. 537.

§ 32.1-315. Solicitation or receipt of remuneration for certain services; offer or payment of remuneration for inducement of such services; penalty.

A. A person shall be guilty of a Class 6 felony and, in addition, may be fined an amount not to exceed $25,000, if he knowingly and willfully solicits or receives any remuneration, including any kickback, bribe or rebate, directly or indirectly, overtly or covertly, in cash or in-kind, or causes such remuneration to be solicited or received:

1. In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under medical assistance; or

2. In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part under medical assistance.

B. A person shall be guilty of a Class 6 felony and, in addition, may be fined an amount not to exceed $25,000, if he knowingly and willfully offers or pays any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in-kind to any person to induce such person, or causes such remuneration to be offered or paid:

1. To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under medical assistance; or

2. To purchase, lease, order, or arrange for or recommend purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part under medical assistance.

C. Subsections A and B shall not apply to:

1. A discount or other reduction in price obtained by a provider of services or other person under medical assistance, if the reduction in price is properly disclosed and appropriately reflected in the cost claimed or charges made by the provider or other person under medical assistance;

2. Any reasonable compensation paid by an employer to an employee who has a bona fide employment relationship with such employer, for employment in the provision of covered items or services;

3. An agreement by health care providers for the group purchase of equipment, goods, services, or supplies which results in fees paid to an agent of the providers, when such agreement has been presented to and authorized by the Department of Medical Assistance Services on the basis that the agreement will reduce the costs of providers of institutional services; and

4. Any remuneration, payment, business arrangement or payment practice that is not prohibited by 42 U.S.C. § 1320a-7b (b) or by any regulations adopted pursuant thereto.

D. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

1981, c. 255; 1986, c. 551; 2003, c. 312; 2010, c. 305.

§ 32.1-316. False statement or representation as to conditions or operations of institution or facility; penalty.

Any person who knowingly, willfully, and fraudulently makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify, either upon initial certification or upon recertification, as a hospital, skilled nursing facility, intermediate care facility, or home care organization shall be guilty of a Class 6 felony. In addition thereto, a fine may be imposed in an amount not to exceed $5,000. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

1981, c. 255; 1991, c. 695; 2010, c. 305.

§ 32.1-317. Collecting excess payment for services; charging, soliciting, accepting or receiving certain consideration as precondition for admittance to facility or requirement for continued stay; penalty.

When the cost of services provided in a facility or by an individual to a patient is paid for, in whole or in part, under medical assistance, any person who:

1. Knowingly and willfully collects or causes to be collected from a patient for any service provided under medical assistance, money or other consideration at a rate in excess of entitlements established by the Department of Medical Assistance Services; or

2. Knowingly and willfully charges, solicits, accepts or receives, or causes to be charged, solicited, accepted, or received any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient, in addition to any amount otherwise required to be paid under medical assistance:

a. As a precondition of admitting a patient to a hospital, skilled nursing facility or intermediate care facility; or

b. As a requirement for the patient's continued stay in such facility;

shall be guilty of a Class 6 felony. In addition thereto, a fine may be imposed in an amount not to exceed $25,000. The Director of the Department of Medical Assistance Services may terminate or deny a contract to a provider for any violation of this section pursuant to § 32.1-325.

1981, c. 255; 1985, c. 153; 2010, c. 305.

§ 32.1-318. Knowing failure to deposit, transfer or maintain patient trust funds in separate account; penalty.

A. Any person having any patient trust funds in his possession, custody or control, who, knowing that he is violating any statute or regulation, deliberately fails to deposit, transfer or maintain such funds in a separate, designated, trust bank account as required by such statute or regulation shall be guilty of a Class 1 misdemeanor.

B. "Patient trust funds" are funds received by any health care facility which belong to patients and are required by any state or federal statute or regulation to be kept in a separate trust bank account for the benefit of such patients.

C. This section shall not be construed to prevent a prosecution pursuant to Chapter 5 (§ 18.2-77 et seq.) of Title 18.2.

1981, c. 255.

§ 32.1-319. Written verification of application, statement or form; penalty for false or misleading information.

The State Board of Medical Assistance Services may require in its Plan for Medical Assistance that any application, statement, or form filled out by suppliers of medical care under medical assistance shall contain or be verified by a written statement that it is made under the penalties of perjury and such declaration shall be in lieu of any oath otherwise required, and each such paper shall in such event so state. Any person who knowingly and willfully makes or subscribes any such papers or forms containing any false or misleading information shall be guilty of a Class 4 misdemeanor.

1981, c. 255; 1984, c. 781.

§ 32.1-319.1. Department to establish pilot program to use data analytics to mitigate risk of improper payments.

A. The Department shall conduct a pilot program to develop and implement means to mitigate the risk of improper payments to providers of services furnished under the state plan for medical assistance and all applicable waivers. The pilot program shall include the use of predictive modeling, provider profiling, trend analysis, and other analytics to identify providers with a high likelihood of fraud, abuse, or error and prevent payments on potentially fraudulent or erroneous claims from being made until such claims have been validated.

B. The Department may enter into a contract or agreement with a vendor for the operation of the pilot program to mitigate the risk of improper payments to providers of services furnished under the state plan for medical assistance and all applicable waivers required by this section. However, selection of a vendor shall be dependent on the demonstration of a proof of concept, prior to entering into a contract or agreement.

2017, c. 750; 2019, c. 422.

§ 32.1-320. Duties of Attorney General; medical services providers audit and investigation unit.

A. There shall be established within the Office of the Attorney General a unit to audit and investigate providers of services furnished under the State Medical Assistance Plan. The Department of Medical

Assistance Services shall cooperate with the Office of the Attorney General in conducting such audits and investigations and shall provide such information for these purposes as may be requested by the Attorney General or his authorized representative.

B. The Attorney General or his authorized representative shall have the authority to:

1. Conduct audits and investigations of providers of medical and other services furnished under medical assistance. Such investigations shall include investigation of complaints alleging abuse or neglect of persons in the care or custody of others who receive payments for providing health care services under the state plan for medical assistance, regardless of whether the patient who is the subject of the complaint is a recipient of medical assistance. The relevant board within the Department of Health Professions shall serve in an advisory capacity to the Attorney General in the conduct of audits or investigations of health care providers licensed by the respective regulatory boards. In the conduct of such audits or investigations, the Attorney General may examine (i) those records or portions thereof, including patient records, for which services were rendered by a health care provider and reimbursed by the Department of Medical Assistance Services under the Plan for Medical Assistance, and (ii) in cases involving a complaint alleging abuse or neglect of a person in the care or custody of others who receive payments for medical assistance, those records or portions thereof, including patient records, that are relevant to the investigation of the complaint, notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2 or of any other statute which may make or purport to make such records privileged or confidential. No original patient records shall be removed from the premises of the health care provider, except in accordance with Rule 4:9 of the Rules of the Supreme Court of Virginia. The disclosure of any records or information by the Attorney General is prohibited, unless such disclosure is directly connected to the official purpose for which the records or information was obtained. The disclosure of patient information as required under this section shall not subject any physician or other health services provider to any liability for breach of any confidential relationship between the provider and the patient, but no evidence resulting from such disclosure may be used in any civil, administrative or criminal proceeding against the patient unless a waiver of the applicable evidentiary privilege is obtained. The Attorney General shall cause all copies of patient medical records in his possession or that of his designee to be destroyed upon completion of the audit, investigation or proceedings, including appeals;

2. Issue subpoenas, propound interrogatories, compel the attendance of witnesses, administer oaths, certify to official acts, take depositions within and without the Commonwealth as now provided by law, and compel the production of pertinent books, payrolls, accounts, papers, records, documents and testimony relevant to such investigation. If a person in attendance before the Attorney General or his authorized representative refuses, without reasonable cause, to be examined or to answer a legal and pertinent question, or to produce a book or paper or other evidence when ordered to do so by the Attorney General or his authorized representative, the Attorney General or his authorized representative may apply to the judge of the circuit court of the jurisdiction where such person is in attendance, upon affidavit, for an order returnable in not less than two nor more than five days, directing such person to

show cause why he should not produce such records. Upon the hearing of such order, if the court shall determine that such person, without reasonable cause, has refused to be examined or to answer a legal or pertinent question, or to produce a book or paper which he was ordered to bring or produce, he may forthwith assess all costs and reasonable attorney fees against such person. If the motion for an order is granted and the person thereafter fails to comply with the order, the court may make such orders as are provided for in the Rules of the Supreme Court of Virginia. Subpoenas shall be served and witness fees and mileage paid as allowed in civil cases in the circuit courts of this Commonwealth. Subpoenas issued under this section are expressly excluded and excepted from the provisions of subsection H of § 32.1-127.1:03. All records, information, reports, documents, memoranda, and communications created or developed during the course of a civil investigation under this section or pursuant to § 32.1-312 shall be considered sensitive and confidential and may be considered attorney work product or privileged investigative files.

1981, c. 255; 1982, c. 41; 1984, c. 781; 1986, c. 551; 2011, cc. 110, 175; 2012, c. 479; 2013, c. 538.

§ 32.1-320.1. Powers and duties of sworn unit investigators.

A. The Attorney General may designate up to 30 persons in the unit established under § 32.1-320 as sworn unit investigators. Any individual designated as a sworn unit investigator shall be sworn only to enforce the provisions of this article. Sworn unit investigators shall be designated as law-enforcement officers as defined in § 9.1-101.

B. All sworn unit investigators shall remain subject to the federal requirements authorizing State Medicaid Fraud Control Units pursuant to 42 C.F.R. Part 1007.

C. If a search warrant is issued for any place of abode, a sworn unit investigator shall notify and request assistance from the State Police or the local law-enforcement agency from the locality where such abode is located prior to executing such search warrant. A sworn unit investigator shall not execute any search warrant for the search of any place of abode unless such sworn unit investigator is accompanied by a State Police officer or a local law-enforcement officer from the locality where such abode is located. Any evidence obtained from a search warrant executed in violation of this subsection shall not be admitted into evidence for the Commonwealth in any prosecution.

2023, c. 619.

§ 32.1-321. Prosecution of cases.

The State Attorney General shall refer cases for prosecution in accordance with the provisions of this chapter to the attorney for the Commonwealth in the city or county where the offense occurred. The attorney for the Commonwealth shall obtain the assistance of the office of the Attorney General in the conduct of litigation arising under this chapter and shall be considered the authorized representative of the Attorney General for the purposes of this chapter.

1981, c. 255.

§ 32.1-321.01. Exemptions from disclosure.

Records or information provided to the Office of the Attorney General pursuant to this article shall be exempt from disclosure pursuant to § 2.2-3705.5.

2011, cc. 110, 175, 535.

Article 2 - REGULATION OF RECIPIENT ELIGIBILITY

§ 32.1-321.1. Powers and duties of Department.

The Department of Medical Assistance Services shall have the following powers and duties:

1. To investigate and refer for prosecution violations of applicable state and federal laws and regulations pertaining to the application for and receipt of services or benefits;

2. To investigate and refer for civil recovery any debts owed to the medical assistance program or funds paid for services or benefits as a result of violations of applicable state and federal laws and regulations pertaining to the application for and receipt of services or benefits; and

3. To cooperate with the federal government, other state agencies and the State Attorney General's Office in the detection and deterrence of fraud by recipients of medical assistance or their agents.

1986, c. 551.

§ 32.1-321.2. Liability for excess benefits or payments obtained without intent to violate this article; recovery of Medical Assistance erroneously paid.

Any person who, without intent to violate this article, obtains benefits or payments under medical assistance to which he is not entitled shall be liable for any excess benefits or payments received. If the recipient knew or reasonably should have known that he was not entitled to the excess benefits, he may also be liable for interest on the amount of the excess benefits or payments at the judgment rate as defined in § 6.2-302 from the date upon which such person knew or reasonably should have known that he had received excess benefits or payments to the date on which repayment is made to the Commonwealth. No person shall be liable for payment of interest, however, when excess benefits or payments were obtained as a result of errors made solely by the Department of Medical Assistance Services.

Any payment erroneously made on behalf of a recipient or former recipient of medical assistance may be recovered by the Department of Medical Assistance Services from the recipient or the recipient's income, assets or estate unless such property is otherwise exempted by state or federal law or regulation.

1986, c. 551.

§ 32.1-321.3. Fraudulently obtaining benefits; liability for fraudulently issued benefits; civil action to recover; penalty.

Any person who, on behalf of himself or another, issues, obtains or attempts to obtain medical assistance benefits by means of (i) knowingly and willfully making or causing to be made any false statement or false representation of material fact; (ii) knowingly and willfully concealing or causing to be

concealed a material fact; or (iii) engaging in any other fraudulent scheme or device shall be liable for repayment of the cost of all benefits issued as a result of such fraud, plus interest on the amount of the benefits issued at the rate of 1.5 percent per month for the period from the date upon which payment was made for such benefits to the date on which repayment is made to the Commonwealth.

Such matters may be referred for criminal action to the attorney for the Commonwealth having jurisdiction over the case. The Attorney General may, independent of any referral to or decision of the attorney for the Commonwealth, petition the circuit court in the jurisdiction of the alleged offense to seek an order assessing civil penalties in the amount of the benefits issued, in addition to repayment and interest and any other penalties provided by law.

All civil penalties shall be deposited in the general fund of the state treasury upon receipt.

1986, c. 551; 1996, cc. 941, 991; 2010, c. 305.

§ 32.1-321.4. False statement or representation in applications for eligibility or for use in determining rights to benefits; concealment of facts; criminal penalty.

A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of larceny and, in addition to the penalties provided in §§ 18.2-95 and 18.2-96 as applicable, may be fined an amount not to exceed $10,000:

1. Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact in an application for eligibility, benefits or payments under medical assistance;

2. Knowingly and willfully falsifying, concealing or covering up by any trick, scheme, or device a material fact or causing a material fact to be falsified, concealed, or covered up in such a manner, in connection with an application for eligibility, benefits or payments;

3. Knowingly and willfully concealing or failing to disclose any event affecting the initial or continued right of any individual to any benefits or payment or causing such concealment or failure to disclose such an event with an intent to secure fraudulently such benefits or payment in a greater amount or quantity than is authorized or when no such benefit or payment is authorized;

4. Knowingly and willfully converting or causing to be converted any benefits or payment received pursuant to an application for another person and receipt of benefits or payment on behalf of such other person to use other than for the health and welfare of the other person; or

5. Knowingly and willfully failing to notify or causing another to fail to notify the local department of social services, through whom medical assistance benefits were obtained, of changes in the circumstances of any recipient or applicant which could result in the reduction or termination of medical assistance services.

B. It shall be the duty of the Director of Medical Assistance Services or his designee to enforce the provisions of this section. A warrant or summons may be issued for violations of which the Director or his designee has knowledge. Trial for violation of this section shall be held in the county or city in which the application for medical assistance was made or obtained.

1986, c. 551; 2002, c. 747; 2010, c. 305.

§ 32.1-322. Repealed.

Repealed by Acts 2015, c. 709, cl. 2.

Chapter 10 - DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Article 1 - General Provisions

§ 32.1-323. Department of Medical Assistance Services.

There is hereby established a Department of Medical Assistance Services, hereinafter referred to in this chapter as the Department. The Department shall be under the direction of the Secretary of Human Resources and a Director of Medical Assistance Services who shall be appointed by the Governor, subject to confirmation by the General Assembly.

1984, c. 781.

§ 32.1-323.1. Department to submit forecast of expenditures.

By November 15 of each year, the Department of Planning and Budget, in cooperation with the Department of Medical Assistance Services, shall prepare and submit an estimate of Medicaid expenditures for the current year and a forecast of such expenditures for the next two years to the House Committees on Appropriations and Health, Welfare and Institutions and to the Senate Committees on Finance and Appropriations and on Education and Health, and to the Joint Legislative Audit and Review Commission.

1996, c. 193; 2000, cc. 593, 605.

§ 32.1-323.2. Elimination of waiting lists for certain waivers.

It is the intent of the General Assembly to eliminate the waiting lists for services pursuant to the Intellectual Disability Medicaid Waiver and the Individual and Family Developmental Disabilities and Support Medicaid Waiver.

In furtherance of this intent, beginning with the fiscal year starting July 1, 2010, and for each fiscal year thereafter, the Department of Medical Assistance Services shall add (i) at least 400 additional funded slots per fiscal year for the Intellectual Disability Medicaid Waiver, and (ii) at least 67 additional funded slots per fiscal year for the Individual and Family Developmental Disabilities and Support Medicaid Waiver, until the waiting lists for the Intellectual Disability Medicaid Waiver and the Individual and Family Developmental Disabilities and Support Medicaid Waiver have been eliminated.

In addition, the Governor shall develop a plan to eliminate the waiting lists for services provided to individuals on the Intellectual Disability Medicaid Waiver and the Individual and Family Developmental Disabilities and Support Medicaid Waiver by the 2018-2020 biennium. The plan shall include provisions to reduce the total number of individuals on the waiting list for the Intellectual Disability Medicaid Waiver by 10 percent in the 2008-2010 biennium. The Governor shall submit the plan to the

chairman of the Joint Commission on Health Care, and the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations by October 1, 2009.

The Department of Medical Assistance Services shall work with the Department of Planning and Budget to incorporate additional costs pursuant to this section in the estimate of Medicaid expenditures required pursuant to § 32.1-323.1.

2009, cc. 228, 303; 2012, cc. 476, 507.

§ 32.1-323.3. Dependents of foreign service members; waiting lists for certain waivers.

The Department of Medical Assistance Services shall amend eligibility criteria for the Community Living waiver and the Family and Individual Support waiver to allow the dependent of a foreign service member who was added to the waiting list for services through such waivers while he was a resident of the Commonwealth to maintain his position on the waiting list following a transfer of the foreign service member to an assignment outside of the Commonwealth, so long as the foreign service member maintains the Commonwealth as his legal residence to which he intends to return following completion of the assignment.

2019, c. 416.

§ 32.1-323.4. Department to facilitate transition of persons between certain waiver programs.

A. To ensure that persons considering transitioning from the Home and Community-Based Services waiver program to the Medicaid Works program have sufficient information to make an informed choice regarding such transition, the Department shall establish a process for (i) conducting a comprehensive needs assessment of a person who chooses to participate in the Medicaid Works program to determine the services such person may need to live and fully participate in his community and (ii) developing a plan of support for such person to guide the person in selection of the best waiver program for his needs.

B. The Department shall establish a process to enable a person who transitions from a Home and Community-Based Services waiver program to the Medicaid Works program to retain his Home and Community-Based Services waiver slot for up to 180 days following the date of such transition.

C. The Department shall establish a process to give priority to individuals previously receiving services through the Home and Community-Based Services waiver program who transitioned to the Medicaid Works program and who subsequently seek to resume services through the Home and Community-Based Services waiver program.

2020, c. 925.

§ 32.1-324. Board of Medical Assistance Services.

A. Notwithstanding the provisions of Chapter 1 (§ 32.1-1 et seq.), there shall be a State Board of Medical Assistance Services hereinafter referred to as the Board. The Board shall consist of eleven residents of the Commonwealth to be appointed by the Governor as follows: five of whom shall be health care providers and six of whom shall not; of these six, at least two shall be individuals with significant

professional experience in the detection, investigation, or prosecution of health care fraud. Any vacancy on the Board, other than by expiration of term, shall be filled by the Governor for the unexpired portion of the term. No person shall be eligible to serve on the Board for more than two full consecutive terms. Appointments shall be made for terms of four years each, except that appointments to fill vacancies shall be made for the unexpired terms. The Board shall meet at such times and places as it shall determine. It shall elect from its members a chairman who shall perform the usual duties of such office. The Board shall submit biennially a written report to the Governor and the General Assembly.

B. The Director shall be the executive officer of the Board but shall not be a member thereof.

C. The Director shall be vested with all the authority of the Board when it is not in session, subject to such rules and regulations as may be prescribed by the Board.

1984, c. 781; 1986, c. 440; 1989, c. 195; 1992, c. 107; 2012, c. 137.

§ 32.1-324.1. Authority to administer oaths, conduct hearings; obtaining relevant documents and other information.

A. The Director of the Department of Medical Assistance Services or his designee is authorized in the exercise and performance of official functions, duties, and powers under the provisions of this title to hold and conduct hearings, to administer oaths, and to take testimony under oath. The Director is authorized to make an ex parte application to the Circuit Court for the City of Richmond for the issuance of a subpoena, in furtherance of any investigation within the jurisdiction of the Department, to request the attendance of witnesses and the production of any relevant records, memoranda, papers, and other documents. The Court is authorized to issue and compel compliance with such subpoena upon a showing of good cause. The Court, upon determining that good cause exists to believe that evidence may be destroyed or altered, may issue a subpoena requiring the production of evidence forthwith.

B. In accordance with federal and state law, the Director or his designee shall conduct hearings on determinations of eligibility or continued eligibility of applicants or recipients for services under the state plan for medical assistance. In addition to the authority conferred upon the Director by subsection A of this section, the Director or his designee, in connection with any such proceedings, may issue subpoenas requiring the attendance of witnesses and the production of records, memoranda, papers, and other documents.

C. Failure or refusal to comply with a subpoena issued pursuant to subsection B of this section shall be punishable as a Class 4 misdemeanor.

1986, c. 440; 1990, c. 383.

§ 32.1-324.2. Director to facilitate communication.

In carrying out his duties under this chapter, the Director shall report to the Governor and members of the General Assembly the activities of facilitating communication between the Department and providers and recipients of health care services.

1999, c. 965.

§ 32.1-324.3. Uninsured Medical Catastrophe Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Uninsured Medical Catastrophe Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller. All contributions from income tax refunds and any other source shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund.

B. Moneys in the Fund shall be used solely for the purposes of providing a source of payment for medical treatment of uninsured medical catastrophes. An uninsured medical catastrophe shall include a life-threatening illness or injury requiring specialized medical treatment, hospitalization, or both. The Board shall promulgate regulations that (i) further define an uninsured medical catastrophe, (ii) establish procedures for distribution of moneys in the Fund to pay for the costs of treating uninsured medical catastrophes, (iii) establish application procedures, and (iv) establish criteria for eligibility for assistance from the Fund and the prioritization and allocation of available moneys among applicants for assistance from the Fund.

C. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Director of Medical Assistance Services.

1999, c. 998.

§ 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 advanced practice registered nurse 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, regardless of whether the student receiving care has an individualized education program or whether the health care service is included in a student's individualized education program. Such services shall include those covered under the state plan for medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for payment of medical assistance for health care services provided through telemedicine services, as defined in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall be required to use proprietary technology or applications in order to be reimbursed for providing telemedicine services;

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

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

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

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

intervention programs. Such provision shall include payment for medical assistance for follow-up audiological examinations as recommended by a physician, physician assistant, advanced practice registered nurse, 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);

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, a health care provider duly licensed by the Commonwealth who provides health care services exclusively through telemedicine services shall not be required to maintain a physical presence in the Commonwealth to be considered an eligible provider for enrollment as a Medicaid provider.

For the purposes of this subdivision, a telemedicine services provider group with health care providers duly licensed by the Commonwealth shall not be required to have an in-state service address to be eligible to enroll as a Medicaid vendor or Medicaid provider group.

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;

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

28. 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 or acute health condition who have had two or more hospitalizations or emergency department visits related to such health condition in the previous 12 months when there is evidence that the use of remote patient monitoring is likely to prevent readmission of such patient to a hospital or emergency department. 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 patients in one location and electronically transmit that information securely to health care providers in a different location for analysis, interpretation, and recommendations, and management of the patient. "Remote patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood

glucose, and other patient physiological data, treatment adherence monitoring, and interactive video-conferencing with or without digital image upload;

29. A provision for the payment of medical assistance for provider-to-provider consultations that is no more restrictive than, and is at least equal in amount, duration, and scope to, that available through the fee-for-service program;

30. A provision for payment of the originating site fee to emergency medical services agencies for facilitating synchronous telehealth visits with a distant site provider delivered to a Medicaid member. As used in 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;

31. A provision for the payment of medical assistance for targeted case management services for individuals with severe traumatic brain injury; and

32. A provision for payment of medical assistance for the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories, as defined by the Department's durable medical equipment program policy, for patients who reside in nursing facilities. Initial purchase or replacement may be contingent upon (i) determination of medical necessity; (ii) requirements in accordance with regulations established through the Department's durable medical equipment program policy; and (iii) exclusive use by the nursing facility resident. Recipients of medical assistance shall not be required to pay any deductible, coinsurance, copayment, or patient costs related to the initial purchase or replacement of complex rehabilitative technology manual and power wheelchair bases and related accessories.

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 pur-

suant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

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

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

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

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

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.

K. When the services provided for by such plan are services by a pharmacist, pharmacy technician, or pharmacy intern (i) performed under the terms of a collaborative agreement as defined in § 54.1-3300

and consistent with the terms of a managed care contractor provider contract or the state plan or (ii) related to services and treatment in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service.

1984, c. 781; 1985, cc. 519, 532, 535, 564; 1986, cc. 393, 455; 1987, cc. 398, 446, 642; 1988, cc. 99, 215, 504, 790; 1989, c. 269; 1990, cc. 395, 793; 1993, cc. 298, 971; 1996, cc. 155, 201, 511, 788, 796, 946; 1997, cc. 671, 683, 730; 1998, cc. 56, 257, 459, 554, 558, 571, 631, 653, 709, 858, 875; 1999, cc. 818, 878, 967, 1005, 1024; 2000, cc. 484, 855, 888; 2001, cc. 334, 534, 663, 859; 2003, cc. 66, 71; 2004, cc. 125, 246, 855; 2006, cc. 396, 425; 2007, cc. 536, 873, 916; 2009, cc. 813, 840; 2010, cc. 305, 785, 790; 2012, cc. 367, 646, 689; 2014, cc. 196, 750; 2017, c. 106; 2019, cc. 211, 219; 2020, cc. 1082, 1083; 2020, Sp. Sess. I, cc. 44, 53; 2021, Sp. Sess. I, cc. 245, 250, 301, 302; 2022, cc. 269, 384, 790, 791; 2022, Sp. Sess. I, c. 11; 2023, cc. 112, 113, 183, 266, 412.

§ 32.1-325.001. Repealed.

Expired.

§ 32.1-325.01. Certain term life insurance considered resources.

When making eligibility determinations for institutional or community-based care to be paid for by the Department, the Department shall consider as an uncompensated transfer all resources that are used by an applicant to purchase any term life insurance policy that does not have a benefit payable at death that will equal or exceed twice the sum of all premiums paid for such policy if such policy was purchased within thirty months prior to the date of application for assistance.

The provisions of this section shall not apply to term life insurance policies for pre-need funerals pursuant to § 54.1-2820, except that any benefits paid under such policy in excess of such actual expenses shall be subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured. The provisions of this section shall not apply to any term life insurance policies purchased prior to the effective date of this law.

1993, c. 990.

§ 32.1-325.02. Determinations of assets; disclaimers of interests to be considered uncompensated transfers of assets for Medicaid eligibility purposes under certain circumstances.

A. When determining eligibility for medical assistance services, "assets" means, in regard to an individual, all income and resources of the individual and the individual's spouse, including, but not limited to, any income or resources which the individual or such individual's spouse is or becomes entitled to, but does not receive, because of any action by such individual or such individual's spouse, or by a person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or such individual's spouse, or by any person, including any court or administrative body, acting at the direction of or upon the request of the individual or such individual's spouse.

B. For the sole purpose of determining eligibility for medical assistance services as provided in this title, Chapter 5 (§ 63.2-500 et seq.) of Title 63.2, and the regulations of the Department of Medical

Assistance Services, any disclaimer of succession pursuant to Chapter 26 (§ 64.2-2600 et seq.) of Title 64.2 shall be considered an uncompensated transfer of assets equal to the value of any interest disclaimed by any person who would, by reason of the disclaimer of succession, retain Medicaid eligibility or become eligible for medical assistance within (i) 36 months of the date that the disclaimer instrument is filed with a court of competent jurisdiction when the disclaimer instrument relates to any property other than property passed through a trust or (ii) 60 months of the date that the disclaimer instrument is filed with a court of competent jurisdiction when the disclaimer instrument relates to payments from a trust or portions of a trust.

1994, c. 765; 2003, c. 253.

§ 32.1-325.03. Legal presence required for certain state and local public benefits; exceptions; definitions; proof of legal presence.

A. In addition to meeting the existing eligibility requirements of the benefits applied for, no person who is not a United States Citizen or legally present in the United States shall receive medical services under this chapter, except for the following:

1. Medicaid benefits for those residing in long-term institutional facilities or participating in home and community based waivers on June 30, 1997, who were eligible for full Medicaid benefits shall continue to be eligible for Medicaid benefits at state expense if federal financial participation is not available;

2. Medicaid benefits for those who because of alien requirements pursuant to the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) (i) are under the age of 19 years and (ii) would be eligible for full Medicaid benefits if the alien requirements prior to the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 were still in effect. However, such person upon reaching the age of 19 years shall comply with the provisions of this section; and

3. State or local public benefits that are mandated by Federal Law pursuant to 8 U.S.C. § 1621.

B. The determination of eligibility for public benefits as provided in this chapter shall be subject to the provisions of § 63.2-503.1, as applicable.

2005, cc. 867, 876.

§ 32.1-325.04. Eligibility for medical assistance; individuals confined in state correctional facilities.

A. The Department shall coordinate with the Department of Corrections to identify persons in the custody of state correctional facilities who are currently enrolled in the Commonwealth's program of medical assistance or who may be eligible for services under the state plan for medical assistance upon release and shall, prior to the release of such persons, (i) review the eligibility of currently enrolled persons to ensure continued access to medical assistance upon release or (ii) enroll persons not previously enrolled who meet eligibility criteria in the Commonwealth's program of medical assistance services; however, no services under the state plan for medical assistance shall be furnished to any

person while he is confined in a state correctional facility unless federal financial participation is available to pay for the cost of the services provided.

B. An individual who is enrolled in the Commonwealth's program of medical assistance services at the time of release from the custody of a state correctional facility shall be eligible for services upon release and shall continue to be eligible for services under the state plan for medical assistance until such time as the person is determined to no longer be eligible for medical assistance.

2022, c. 300.

§ 32.1-325.1. Adverse initial determination of overpayment; appeals of agency determinations.

A. The Director shall make an initial determination as to whether an overpayment has been made to a provider in accordance with the state plan for medical assistance, the provisions of § 2.2-4019 and applicable federal law. The initial determination shall be issued within 180 days of the receipt of the appeal request. If the agency does not render a decision within 180 days, the decision is deemed to be in favor of the provider.

B. An appeal of the Director's initial determination concerning provider reimbursement shall be heard in accordance with § 2.2-4020 of the Administrative Process Act (§ 2.2-4020 et seq.) and the state plan for medical assistance provided for in § 32.1-325. The hearing officer appointed pursuant to § 2.2-4024 shall conduct the appeal and submit a recommended decision to the Director within 120 days of the agency's receipt of the appeal request. The Director shall consider the parties' exceptions and issue the final agency case decision within sixty days of receipt of the hearing officer's recommended decision. If the Director does not render a final agency case decision within sixty days of the receipt of the hearing officer's recommended decision, the decision is deemed to be in favor of the provider. The Director shall adopt the hearing officer's recommended decision unless to do so would be an error of law or Department policy. Any final agency case decision in which the Director rejects a hearing officer's recommended decision shall state with particularity the basis for rejection. Prior to a final agency case decision issued in accordance with § 2.2-4023, the Director may not undertake recovery of any overpayment amount paid to the provider through offset or other means. Once a final determination of overpayment has been made, the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial or the final determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's determination becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein.

C. The burden of proof in informal and formal administrative appeals is on the provider. The agency shall reimburse a provider for reasonable and necessary attorneys' fees and costs associated with an informal or formal administrative appeal if the provider substantially prevails on the merits of the appeal and the agency's position is not substantially justified, unless special circumstances would make an award unjust. In any case in which a provider has recovered attorneys' fees and costs

associated with an informal or formal administrative appeal, the provider shall not be entitled to recover those same attorneys' fees and costs in a subsequent judicial proceeding.

D. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act (§ 2.2-4000 et seq.). In any case in which a final determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest, within thirty days of the subsequent judicial order.

1986, c. 441; 2000, c. 967.

§ 32.1-325.1:1. Definitions; recovery of overpayment for medical assistance services.

A. For the purposes of this section, the following definitions shall apply:

"Agreement" means any contract executed for the delivery of services to recipients of medical assistance pursuant to subdivision D 2 of § 32.1-325.

"Successor in interest" means any person as defined in § 1-230 having stockholders, directors, officers, or partners in common with a health care provider for which an agreement has been terminated.

"Termination" means (i) the cessation of operations by a provider, (ii) the sale or transfer of the provider, (iii) the reorganization or restructuring of the health care provider, or (iv) the termination of an agreement by either party.

B. The Director of Medical Assistance Services shall collect by any means available to him at law any amount owed to the Commonwealth because of overpayment for medical assistance services. Upon making an initial determination that an overpayment has been made to the provider pursuant to § 32.1-325.1, the Director shall notify the provider of the amount of the overpayment. Such initial determination shall be made within the earlier of (i) four years, or (ii) 15 months after filing of the final cost report by the provider subsequent to sale of the facility or termination of the provider. The provider shall make arrangements satisfactory to the Director to repay the amount due. If the provider fails or refuses to make arrangements satisfactory to the Director for such repayment or fails or refuses to repay the Commonwealth for the amount due for overpayment in a timely manner, the Director may devise a schedule for reducing the Medicaid reimbursement due to any successor in interest.

C. In any case in which the Director is unable to recover the amount due for overpayment pursuant to subsection B, he shall not enter into another agreement with the responsible provider or any person who is the transferee, assignee, or successor in interest to such provider unless (i) he receives satisfactory assurances of repayment of all amounts due or (ii) the agreement with the provider is necessary in order to ensure that Medicaid recipients have access to the covered services rendered by the provider.

Further, to the extent consistent with federal and state law, the Director shall not enter into any agreement with a provider having any stockholder possessing a material financial interest, partner, director,

officer, or owner in common with a provider which has terminated a previous agreement for participation in the medical assistance services program without making satisfactory arrangements to repay all outstanding Medicaid overpayment.

D. The provisions of this section shall not apply to successors in interest with respect to transfer of a medical care facility pursuant to contracts entered into before February 1, 1990.

1990, c. 389; 1994, c. 669; 1999, c. 1024; 2005, c. 839.

§ 32.1-325.2. Department is payor of last resort.

A. Insurers, including group health plans as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, self-insured plans, health services plans, service benefit plans, health maintenance organizations, managed care organizations, pharmacy benefits managers, or other parties that are, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service, are prohibited from including any clause in health care contracts which would exclude enrolling an individual or in making any payment for benefits to the individual or on the individual's behalf for health care when the individual is eligible for medical assistance.

B. The Department of Medical Assistance Services shall be the payor of last resort to any insurer, including a group health plan as defined in § 607(1) of the Employee Retirement Income Security Act of 1974, a self-insured plan, a health services plan, a service benefit plan, a health maintenance organization, a managed care organization, a pharmacy benefits manager, or other party that is, by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service for persons eligible for medical assistance in the Commonwealth. The above entities, as a condition of doing business in the Commonwealth, shall comply with the requirements set forth in 42 U.S.C. 1396a (a) (25) (I) (i)-(iv).

C. To the extent the Department of Medical Assistance Services has made payment for medical services where a third party has a legal obligation to make payment for such services, the Commonwealth shall automatically acquire all rights to such payment from the third party.

D. To the extent the Department of Medical Assistance Services is permitted by law to obtain recoveries from third parties, actions at law for such recoveries shall be decided under the same laws, rules and standards including applicable bases of liability and defenses as would apply if the individual receiving the services had brought the action directly; provided that nothing herein shall affect the sovereign immunity of the Commonwealth.

E. The term "insurer" as used herein shall be deemed to include without limitation "insurance carriers."

1986, c. 550; 1994, c. 213; 1996, c. 851; 2007, c. 535.

§ 32.1-325.3. Disclosure or use of information for purpose not connected with medical assistance program; Department not subject to certain disclosure.

A. The Board of Medical Assistance Services shall promulgate regulations consistent with federal law to provide safeguards against the use or disclosure of information, including information provided to a managed care organization pursuant to § 32.1-330.5, concerning applicants for and recipients of medical assistance services for any purpose that is not directly connected with the administration of the state plan for medical assistance services.

B. Information in the possession or control of the Department or a managed care organization pursuant to § 32.1-330.5 concerning applicants for and recipients of medical assistance services shall not be subject to disclosure through discovery in litigation to which the Department is not a necessary party, unless the appropriate circuit court, for good cause shown, shall order such disclosure.

1989, c. 67; 1992, c. 107; 2018, c. 382.

§ 32.1-325.4. Penalty for violation.

Any person who willfully violates or refuses, fails, or neglects to comply with any regulation or order of the Board or the Director promulgated pursuant to § 32.1-325.3 shall be guilty of a Class 1 misdemeanor.

1989, c. 67.

§ 32.1-326. Director may make payments to or for eligible persons in state-owned medical facilities.

The Director of Medical Assistance Services is authorized, subject to the state plan provided for in § 32.1-325 and any other regulations of the Board, to make payments to or on behalf of eligible persons in state-owned mental hospitals, nursing or geriatric units or other state-owned medical facilities.

1984, c. 781.

§ 32.1-326.1. Department to operate program of estate recovery.

In accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, the Department shall operate a program of estate recovery for all persons who receive payments or on whose behalf payments are made for Medicaid-financed nursing facility care by the Department. The amount recovered from the estate of a deceased recipient shall not exceed the amount of total Medicaid payments made on behalf of such recipient.

1993, cc. 193, 700.

§ 32.1-326.2. Pilot school/community health centers.

The Department of Medical Assistance Services, in cooperation with the Department of Education, shall, consistent with the biennium budget cycle, examine and may revise the funding and components of the pilot school/community health centers. Any revisions shall be designed to maximize access to health care for poor children, and to improve the funding by making use of every possible, cost-effective means, Medicaid reimbursement or program. Any revisions shall be focused on prevention of large costs for acute or medical care and may include, but not be limited to:

1. Funding sources and means of distribution for the state match which will clearly demonstrate that local governments are not funding the state match for these centers.

2. The benefits and drawbacks of allowing school divisions to provide services to disabled students as Medicaid providers.

3. The appropriate credentials of the providers of care in the school health centers, e.g., licensure by the Board of Education and compliance with federal requirements or licensure by a regulatory board within the Department of Health Professions.

4. Utilization of the individualized education plan, when signed by a physician, as the plan of care authorizing services.

5. Delivery of medically necessary services, such as rehabilitation services, psychiatric and psychological evaluations and therapy, transportation, and nursing.

6. Payment for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, with proper medical oversight, in consultation with the students' primary care physicians.

7. The role of the Medallion and Options programs in regard to the school health centers and flexibility for school divisions regarding any required referrals.

Any funds necessary to support revisions to the school/community health center projects shall be included in the budget estimates for the departments, as appropriate.

1996, c. 864.

§ 32.1-326.3. Special education health services; memorandum of agreement between the Department of Education and the Department of Medical Assistance Services.

A. The Department of Medical Assistance Services, in cooperation with the Department of Education, shall, consistent with the biennium budget cycle, examine and revise, as necessary, the regulations relating to the funding and components of special education services.

Any revisions shall be designed to maximize access to health care for poor children who are eligible for medical assistance services and to assist school divisions in the funding of medically necessary related services by making use of every possible, cost-effective means, Medicaid reimbursement or other program administered by the Department of Medical Assistance Services, including, but not limited to, the State Children's Health Insurance Plan pursuant to Title XXI of the United States Social Security Act, as approved by the federal Health Care Financing Administration at the time. Any revisions shall be based on the flexibility allowed to the states and be focused on avoiding large costs for acute or medical care and increasing children's access to health care, and shall include, but need not be limited to:

1. Rates for services which shall clearly identify that only the federal share shall be reimbursed for the special education health services and shall demonstrate that local governments are funding the state match for the special education health services provided by school divisions.

2. The benefits and drawbacks of allowing school divisions to provide services as Medicaid providers to disabled students.

3. The appropriate credentials of the providers of care, in compliance with federal requirements and with the approval of the Health Care Financing Administration, for special education health services; e.g., licensure by the Board of Education and licensure by the appropriate health regulatory board within the Department of Health Professions.

4. Delivery of medically necessary related services for students who are eligible for medical assistance services.

The services shall be limited to those services which are covered under the then-current state plan for medical assistance services, and may be provided, consistent with federal law and as approved by the Health Care Financing Administration, by a school division participating as a health services provider. Such services shall include, but need not be limited to, speech therapy, including such services when delivered by school speech-language pathologists licensed by the Board of Audiology and Speech-Language Pathology or those individuals who are directly supervised, at least twenty-five percent of the time, by such licensed speech-language pathologists; physical therapy; occupational therapy; psychiatric and psychological evaluations and therapy, including such services when delivered by school psychologists-limited licensed by the Board of Psychology; transportation between the student's home, the school or other site where health-related services are to be provided on those days when the student is scheduled to receive such services at the school or such other site; and skilled nursing services, such as health assessments, screening activities, nursing appraisals, nursing assessments, nursing procedures, medication assessment, medication monitoring, and medication administration.

5. The role of the Medallion, Medallion II, Options or other managed care programs in regard to the special education health services and coordination with school divisions regarding any required referrals.

B. Any funds necessary to support revisions to the special education health services shall be included in the budget estimates for the departments, as appropriate.

C. The Director of the Department of Medical Assistance Services or his designee and the Superintendent of Public Instruction or his designee shall develop and execute a memorandum of agreement relating to special education health services. This memorandum of agreement shall be revised on a periodic basis; however, the agreement shall, at a minimum, be revised and executed within six months of the inauguration of a new governor in order to maintain policy integrity.

D. The agreement shall include, but need not be limited to, (i) requirements for regular and consistent communications and consultations between the two departments and with school division personnel and officials and school board representatives; (ii) a specific and concise description and history of the federal Individuals with Disabilities Education Act (IDEA), a summary of school division responsibilities pursuant to the Individuals with Disabilities Education Act, and a summary of any

corresponding state law which influences the scope of these responsibilities; (iii) a specific and concise summary of the then-current Department of Medical Assistance Services regulations regarding the special education health services; (iv) assignment of the specific responsibilities of the two state departments for the operation of special education health services; (v) a schedule of issues to be resolved through the regular and consistent communications process, including, but not limited to, ways to integrate and coordinate care between the Department of Medical Assistance Services' managed care providers and special education health services providers; (vi) a process for the evaluation of the services which may be delivered by school divisions participating as special education health services providers pursuant to Medicaid; (vii) a plan and schedule to reduce the administrative and paperwork burden of Medicaid participation on school divisions in Virginia; and (viii) a mechanism for informing primary care providers and other case management providers of those school divisions that are participating as Medicaid providers and for identifying such school divisions as Medicaid providers that are available to receive referrals to provide special education health services.

E. The Board of Medical Assistance Services shall cooperate with the Board of Education in developing a form to be included with the Individualized Education Plan (IEP) that shall be accepted by the Department of Medical Assistance Services as the plan of care (POC) and in collecting the data necessary to establish separate and specific Medicaid rates for the IEP meetings and other services delivered by school divisions to students.

The POC form shall (i) be consistent with the plan of care required by the Department of Medical Assistance Services of other Medicaid providers, (ii) allow for written updates, (iii) be used by all school divisions participating as Medicaid providers of special education health services, (iv) document the student's progress, and (v) be integrated and coordinated with the Department of Medical Assistance Services' managed care providers.

F. The Department of Medical Assistance Services shall consult with the Department of Education in preparing a consent form which (i) is separate from the IEP, (ii) includes a statement noting that such form is not part of the student's IEP, (iii) includes a release to authorize billing of school-based health services delivered to the relevant student by the school division, and (iv) shall be used by all school divisions participating in Medicaid reimbursement. This consent form shall be made available to the parents upon conclusion of the IEP meeting. The release shall allow for billing of school-based health services by Virginia school divisions to the Virginia Medicaid program and other programs operated by the Department of Medical Assistance Services.

G. The Department of Medical Assistance Services and the Department of Education shall also develop a cost-effective, efficient, and appropriate process to allow school divisions access to eligibility data for students for whom consent has been obtained.

H. The Board of Medical Assistance Services shall, when in compliance with federal law and regulation and approved by the Health Care Financing Administration, also (i) include, in its regulations which provide for reimbursement of school divisions participating in Medicaid as special education

health services providers, a provision for reimbursement of mental health services delivered by licensed school psychologists-limited and a provision for reimbursement for services rendered to Medicaid-eligible students of speech-language pathology services delivered by school speech-language pathologists or those individuals who are directly supervised, at least twenty-five percent of the time, by such licensed speech-language pathologists; (ii) revise the limitations, established pursuant to relevant regulations and Virginia's state plan for medical assistance services, on services delivered by school divisions participating in Medicaid as special education health services providers, in effect on January 1, 1999, for physical therapy, occupational therapy, and speech, hearing, and language disorders when such services are rendered to children who are eligible for special education services and have IEPs requiring such services; (iii) cooperate with the Board of Education in developing a form to be included with the IEP that shall be accepted by the Department of Medical Assistance Services as the plan of care when signed by a physician or, when under such physician's supervision, his designee; (iv) cooperate with the Board of Education in collecting the data necessary to establish separate and specific rates for the IEP services delivered by school divisions to students with disabilities who are eligible for special education and for medical assistance services; and (v) analyze the data necessary for such rates and establish new rates for reimbursement of IEP meetings based on such data.

I. Services delivered by school divisions as participating providers in the Medicaid program or any other program operated by the Department of Medical Assistance Services shall not include any family planning, pregnancy or abortion services.

1999, cc. 967, 1005; 2002, c. 457; 2021, Sp. Sess. I, c. 250.

§ 32.1-327. Claim against indigent's estate for payments made.

In accordance with applicable federal law and regulations, including those under Title XIX of the Social Security amendments of 1965, the Department may make claim against the estate of an indigent or medically indigent person for the amount of any medical assistance payments made on his behalf by the Department. The Department may waive its claim if it determines that enforcement of the claim would result in substantial hardship to the heirs or dependents of the individual against whose estate the claim exists.

1984, c. 781.

§ 32.1-328. Repealed.

Repealed by Acts 2003, c. 428, cl. 2.

§ 32.1-329. Repealed.

Repealed by Acts 1999, c. 728, effective July 1, 2000.

§ 32.1-330. Long-term services and supports screening required.

A. As used in this section, "acute care hospital" includes an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

B. Every individual who applies for or requests community or institutional long-term services and supports as defined in the state plan for medical assistance services may choose to receive services in a community or institutional setting. Every individual who applies for or requests community or institutional long-term services and supports shall be afforded the opportunity to choose the setting and provider of long-term services and supports.

C. Every individual who applies for or requests community or institutional long-term services and supports shall be screened prior to admission to such community or institutional long-term services and supports to determine his need for long-term services and supports, including nursing facility services as defined in the state plan for medical assistance services. The type of long-term services and supports screening performed shall not limit the long-term services and supports settings or providers for which the individual is eligible.

D. If an individual who applies for or requests long-term services and supports as defined in the state plan for medical assistance services is residing in a community setting at the time of such application or request, the screening for long-term services and supports required pursuant to subsection C shall be completed by a long-term services and supports screening team that includes a nurse, social worker or other assessor designated by the Department who is an employee of the Department of Health or the local department of social services and a physician who is employed or engaged by the Department of Health.

E. If an individual who applies for or requests long-term services and supports as defined in the state plan for medical assistance services is receiving inpatient services in an acute care hospital at the time of such application or request and will begin receiving long-term services and supports as defined in the state plan for medical assistance services pursuant to a discharge order from an acute care hospital, the screening for long-term services and supports required pursuant to subsection C shall be completed by the acute care hospital in accordance with the screening requirements established by the Department.

F. If an individual who applies for or requests long-term services and supports as defined in the state plan for medical assistance services is receiving skilled nursing services that are not covered by the Commonwealth's program of medical assistance services in an institutional setting following discharge from an acute care hospital, the Department shall require qualified staff of the skilled nursing institution to conduct the long-term services and supports screening in accordance with the requirements established by the Department, with the results certified by a physician prior to the initiation of long-term services and supports under the state plan for medical assistance services.

G. If an individual is admitted to a skilled nursing facility for skilled nursing services and such individual was not screened but is subsequently determined to have been required to be screened prior to admission to the skilled nursing facility, then the qualified staff designated in subsection F may conduct a screening after admission. Coverage of institutional long-term services and supports under this subsection by the Commonwealth's program of medical assistance services indicated by the

screening shall not begin until six months after the initial admission to the skilled nursing facility. During this six-month period, the nursing home in which the individual resides shall be responsible for all costs indicated for institutional long-term services and supports that would otherwise have been covered by the Commonwealth's program of medical assistance services, without accessing patient funds. Six months after the date of admission to the skilled nursing facility, and as indicated through the eligibility determination, the Commonwealth's program of medical assistance services shall assume coverage of such services. To the extent that sufficient evidence is provided to indicate that the admission without screening was of no fault of the skilled nursing facility, the Department shall begin coverage of institutional long-term services and supports under this subsection by the Commonwealth's program of medical assistance services immediately upon the completion of the functional screening indicating nursing facility level of care pending the financial eligibility determination.

H. In any jurisdiction in which a long-term services and supports screening team described in subsection D or E has failed or is unable to perform the long-term services and supports screenings required by subsection D or E within 30 days of receipt of the individual's application or request for long-term services and supports under the state plan, the Department shall enter into contracts with other public or private entities to conduct such long-term services and supports screenings in addition to or in lieu of the long-term services and supports screening teams described in subsections D and E.

I. The Department shall require all individuals who perform long-term services and supports screenings pursuant to this section to receive training on and be certified in the use of the long-term services and supports screening tool for eligibility for community or institutional long-term services and supports provided in accordance with the state plan for medical assistance services prior to conducting such long-term services and supports screenings.

J. The Department shall report annually by August 1 to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health regarding (i) the number of long-term services and supports screenings for eligibility for community and institutional long-term services and supports conducted pursuant to this section and (ii) the number of cases in which the Department or the public or private entity with which the Department has entered into a contract to conduct such long-term services and supports screenings fails to complete such long-term services and supports screenings within 30 days.

1984, c. 781; 1990, c. 716; 2003, c. 480; 2014, cc. 285, 413; 2015, c. 542; 2017, c. 749; 2019, c. 430; 2020, cc. 304, 365; 2023, cc. 184, 185.

§ 32.1-330.01. Reports related to long-term services and supports.

A. The Department shall (i) develop a program for the training and certification of individuals who perform long-term services and supports screenings for community and institutional long-term services and supports provided in accordance with the state plan for medical assistance services and ensure that all screeners are trained on and certified in the use of the long-term services and supports screening tool for long-term services and supports screening, (ii) develop guidelines for a standardized long-

term services and supports screening process for community and institutional long-term services and supports provided in accordance with the state plan for medical assistance services and ensure that all long-term services and supports screenings are performed in accordance with such guidelines, (iii) establish and monitor performance according to established standards, and (iv) strengthen oversight of the long-term services and supports screening process for community and institutional long-term services and supports to ensure that problems are identified and addressed promptly.

B. The Department shall require managed care organizations that provide managed long-term services and supports in the Commonwealth to develop the portion of the plan of care addressing the type and amount of long-term services and supports for each recipient. For recipients of long-term services and supports, the managed care organization shall participate in and collaborate with the existing interdisciplinary care team planning process already established pursuant to federal law and regulations in the development of the care plan.

C. The Department shall work with its actuary to (i) ensure that trends are consistent with Actuarial Standards of Practice, including consideration of negative historical trends in medical spending by managed care organizations to be carried forward when setting capitation rates paid to managed care organizations through the managed care program where appropriate, and (ii) annually rebase administrative expenses per member per month for projected enrollment changes and future program changes impacting administrative costs beginning in Fiscal Year 2019.

D. The Department shall include additional financial and utilization reporting requirements in contracts with managed care organizations and the Managed Care Technical Manual, including requirements for submission of (i) income statements that show medical services expenditures by service category, (ii) statements of revenues and expenses, (iii) information about related party transactions, and (iv) information about service utilization metrics, and shall monitor data submitted by managed care organizations to identify undesirable trends in spending and service utilization and work with managed care organizations to address such trends.

E. The Department shall (i) establish a compliance enforcement review process and apply consistent and uniform compliance standards in accordance with the Managed Care Technical Manual, managed care contracts, and federal standards; (ii) return all compliance feedback to managed care organizations within the same reporting or auditing period in which such reports were generated; (iii) review the reasons for which the Commonwealth will mitigate or waive sanctions imposed on managed care organizations that fail to fulfill contract requirements and review and consider infractions due to unforeseen circumstances beyond the managed care organization's control, infractions occurring during the first year of the managed care organization's operation, infractions occurring for the first time, and infractions that are self-reported by the managed care organization; (iv) when applicable, include guidance in the Managed Care Technical Manual for managed care organizations that state the reasons for which sanctions may be mitigated or waived; (v) include information about the number of sanctions mitigated or waived and the reasons for such mitigation or waiver in its monthly compliance reports; and (vi) annually review the results of its contract compliance enforcement action process and include

information about the process and results, including the percentage of points and fines mitigated or waived and the reasons for mitigating them for each managed care organization, in its annual report.

F. The Department shall (i) incrementally increase the amount of performance incentive awards granted to managed care organizations that meet certain performance goals to create a stronger incentive for managed care organizations to improve performance and (ii) retain at least one metric related to chronic conditions in the performance incentive award program.

G. The Department shall work collaboratively with managed care organizations and relevant stakeholders, where appropriate, to annually publish a uniform and agreed-upon managed care organization report card for the Department for the managed care program and shall make such information available to new enrollees as part of the enrollment process.

H. Upon the inclusion of behavioral health services in the managed care program and implementation of managed long-term services and supports, the Department shall require all managed care organizations participating in the managed care program to provide to the Department information about (i) the managed care organization's policies and processes for identifying behavioral health providers who provide services deemed to be inappropriate to meet the behavioral health needs of the individual receiving services and (ii) the number of such providers that are disenrolled from the managed care provider's provider network.

I. The Department shall develop a process that allows managed care organizations providing services through the managed care program to determine utilization control measures for services provided but includes monitoring of the impact of utilization controls on utilization rates and spending to assess the effectiveness of each managed care organization's utilization control measures.

J. The Department shall include language in contracts for managed care long-term services and supports requiring managed care organizations providing services through the managed care program to develop a plan that includes (i) a standardized process to determine the capacity of individuals receiving services to self-direct services received, (ii) criteria for determining when a person receiving services is no longer able to self-direct services received, and (iii) the roles and responsibilities of service facilitators, including requirements to regularly verify that appropriate services are provided.

K. Following inclusion of managed long-term services and supports in the managed care program, the Department shall (i) review information about utilization and spending on long-term services and supports provided by managed care organizations and work with managed care organizations to make necessary changes to managed care organizations' prior authorization and quality management review processes when undesirable trends are identified; (ii) include revenue and expense reports, information about related party transactions, and information about service utilization metrics in contracts for managed long-term services and supports and the Managed Care Technical Manual and utilize data and information received from managed long-term services and supports providers to monitor spending and utilization trends for managed long-term services and supports and address problems related to spending and utilization of services through managed long-term services and supports

program contracts or the rate-setting process; (iii) include additional requirements for information about metrics related to behavioral health services in the managed long-term services and supports contract and the Managed Care Technical Manual to facilitate identification of undesirable trends in service utilization and enable the Department to address problems identified with managed care organizations participating in the program; and (iv) include additional metrics related to the long-term services and supports in the managed long-term services and supports contract and the Managed Care Technical Manual to facilitate identification of differences between models of care, assessment of progress in and challenges related to keeping service recipients in community-based rather than institutional care, and cooperation with managed care organizations in resolving problems identified.

2017, c. 749; 2020, cc. 304, 365.

§ 32.1-330.1. Department to implement premium assistance program for HIV-positive individuals.

The Board of Medical Assistance Services shall from funds eligible for this purpose from Title II of the Ryan White Comprehensive AIDS Resources Emergency CARE Act (42 U.S.C. § 300ff-21 et seq.) or other funds appropriated or made available for this purpose, implement, and may promulgate any necessary regulations for implementation of, a premium assistance program for HIV-positive individuals which shall have, at minimum, the following characteristics:

1. Payment of health insurance premiums for individuals who are not eligible for Medicaid and who can document (i) HIV infection and inability to continue working for medical reasons and (ii) eligibility to continue their employer's group policy pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985;

2. Financial eligibility criteria allowing a maximum income of no more than 250 percent of the federal poverty guidelines and countable liquid assets of no more than $10,000 in value;

3. Funds eligible under Title II of the Ryan White CARE Act shall not be used toward copayments and deductible payments; and

4. Coverage of family members, if the HIV-infected person's policy is the sole source of health insurance.

1994, c. 200; 1996, c. 195; 2000, c. 870.

§ 32.1-330.2. Medicaid managed care programs; program information documents; plain language required.

A. As used in this section, "program information" means all forms of communication that (i) are provided to any person who is an applicant for or a recipient of medical assistance services provided by the Commonwealth pursuant to Titles XIX and XXI of the Social Security Act and (ii) describe eligibility requirements, available medical assistance services, and the rights and responsibilities of recipients of medical assistance services provided by the Commonwealth pursuant to Titles XIX and XXI of the Social Security Act.

B. The Board of Medical Assistance Services shall require that all program information be (i) communicated in nontechnical, readily understandable, plain language and (ii) made available in a manner that is timely and accessible to (a) individuals with limited English proficiency through the provision of language access services, including oral interpretation and written translations, and (b) individuals with disabilities through the provision of auxiliary aids services, when doing so is a reasonable step to providing meaningful access to health care coverage. A person that makes program information available may consider resources, including staffing, available to such person and the cost of responding to requests for language access or auxiliary aids services in determining the reasonableness of making program information available pursuant to this subsection.

C. Language access services and auxiliary aids services provided to ensure program information is accessible to individuals with limited English proficiency and individuals with disabilities shall be provided without charge to such individuals. Information regarding how to receive language access services and auxiliary aids services shall be included with program information documents on a website maintained by the Department and on the website of every state or local government agency or state agency contractor that provides program information.

D. Every person that provides program information shall use an objective readability measure approved by the Department to test the readability of its program information documents. The requirements of this subsection shall not apply to language that is mandated by federal or state laws, regulations, or agencies.

E. All program information documents within the scope of this section, and all amendments thereto, shall be made available for review upon the request of the Department. Any program information document that is exempt from the requirements of subsection B shall be accompanied by a documentation of the federal or state law, regulation, or agency mandate that authorizes the exemption.

1996, c. 318; 2022, c. 775.

§ 32.1-330.3. Operation of a PACE plan; oversight by Department of Medical Assistance Services.

A. As used in this section, unless the context requires a different meaning, "PACE" means of or associated with long-term care health plans (i) authorized as programs of all-inclusive care for the elderly by Subtitle I (§ 4801 et seq.) of Chapter 6 of Title IV of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 528 et seq., §§ 4801-4804, 1997, pursuant to Title XVIII and Title XIX of the United States Social Security Act (42 U.S.C. § 1395eee et seq.), and the state plan for medical assistance services as established pursuant to Chapter 10 (§ 32.1-323 et seq.) and (ii) which have signed agreements with the Department of Medical Assistance Services as long-term care health plans.

B. Operation of a PACE plan that participates in the medical assistance services program shall be in accordance with a prepaid health plan contract or other PACE contract consistent with Chapter 6 of Title IV of the federal Balanced Budget Act of 1997 with the Department of Medical Assistance Services.

C. All contracts and subcontracts shall contain an agreement to hold harmless the Department of Medical Assistance Services and PACE enrollees in the event that a PACE provider cannot or will not pay for services performed by the subcontractor pursuant to the contract or subcontract.

D. During the PACE period, the plan shall have a fiscally sound operation as demonstrated by total assets being greater than total unsubordinated liabilities, sufficient cash flow and adequate liquidity to meet obligations as they become due, and a plan for handling insolvency approved by the Department of Medical Assistance Services.

E. The PACE plan must demonstrate that it has arrangements in place in the amount of, at least, the sum of the following to cover expenses in the event of insolvency:

1. One month's total capitation revenue to cover expenses the month prior to insolvency; and

2. One month's average payment of operating expenses to cover potential expenses the month after the date of insolvency has been declared or operations cease.

The required arrangements to cover expenses shall be in accordance with the PACE Protocol as published by On Lok, Inc., in cooperation with the Centers for Medicare and Medicaid Services, as of April 14, 1995, or any successor protocol that may be agreed upon between the Centers for Medicare and Medicaid Services and On Lok, Inc.

Appropriate arrangements to cover expenses shall include one or more of the following: reasonable and sufficient net worth, insolvency insurance, letters of credit, or parental guarantees.

F. Enrollment in a PACE plan shall be restricted to those individuals who participate in programs authorized pursuant to Title XIX or Title XVIII of the United States Social Security Act, respectively.

G. Full disclosure shall be made to all individuals in the process of enrolling in the PACE plan that services are not guaranteed beyond a 30-day period.

H. The Board of Medical Assistance Services shall establish a Transitional Advisory Group to determine license requirements, regulations, and ongoing oversight. The Advisory Group shall include representatives from each of the following organizations: Department of Medical Assistance Services, Department of Social Services, Department of Health, Bureau of Insurance, Board of Medicine, Board of Pharmacy, Department for Aging and Rehabilitative Services, and a PACE provider.

I. The Department shall develop and implement a coordinated plan to provide choice and education about the PACE program. The plan shall ensure that:

1. Information about the availability and potential benefits of participating in the PACE program is provided to all eligible long-term services and supports clients as part of the long-term services and supports screening process pursuant to § 32.1-330. The client's choice regarding participation in the PACE program shall be documented on the state long-term services and supports screening authorization form. The Department shall provide initial and ongoing training of all long-term services and supports screening teams on the PACE program.

2. The Department develops informational materials and correspondence, including the initial and annual enrollment letters, for use by the Department and its contractors to educate and notify potentially eligible clients about long-term services and supports. These informational materials shall include the following:

a. A description of the PACE program;

b. A statement that an eligible individual has the option to enroll in the PACE program or be automatically enrolled in a managed care organization; and

c. Contact information for PACE providers.

1997, cc. 414, 475; 1998, c. 318; 2012, cc. 803, 835; 2019, c. 419; 2020, cc. 304, 365.

§ 32.1-330.4. Uniform assessment instrument for PACE plans.

Every individual who requests a screening for the purpose of enrollment in a PACE plan, as defined in § 32.1-330.3, shall be eligible for such screening, regardless of whether the individual is eligible under the state plan for medical assistance.

2014, c. 413.

§ 32.1-330.5. Reports related to eligibility renewal.

The Department of Medical Assistance Services shall provide a quarterly report to each managed care organization that is contracted with the Department to provide services through the Medicaid managed care program that specifies the medical assistance application renewal date for each recipient of medical assistance services who has been attributed to the managed care organization.

2018, c. 382.

§ 32.1-331. Repealed.

Repealed by Acts 1989, c. 618.

§ 32.1-331.01. Health Care Coverage Assessment Fund.

A. As used in this section:

"Covered hospital" means any in-state private acute care hospital other than a hospital classified as a public hospital, freestanding psychiatric and rehabilitation hospital, children's hospital, long stay hospital, long-term care hospital, or critical access hospital.

"Newly eligible adult" means an individual described in 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

"State Plan" means the state plan for medical assistance under Title XIX (42 U.S.C. § 1396 et seq.) of the Social Security Act.

B. There is hereby created in the state treasury a special nonreverting fund to be known as the Health Care Coverage Assessment Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All revenues collected or received as a result of imposition of a health care coverage assessment on covered hospitals and any other such moneys, public or private, received for the administration of the health care coverage assessment shall be paid into the state

treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys deposited to the Fund shall be used solely for the nonfederal share of the cost of medical assistance for newly eligible adults, the administrative costs of collecting the assessment and implementing and operating the coverage for newly eligible adults. Such moneys shall be appropriated as provided in the general appropriation act. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Director of the Department of Medical Assistance Services.

2018, Sp. Sess. I, c. 2.

§ 32.1-331.02. Health Care Provider Payment Rate Assessment Fund.

A. As used in this section:

"Covered hospital" means any in-state private acute care hospital other than a hospital classified as a public hospital, freestanding psychiatric and rehabilitation hospital, children's hospital, long stay hospital, long-term care hospital, or critical access hospital.

"Managed care organization hospital payment gap" means the difference between the amount included in rates for inpatient and outpatient services provided by covered hospitals, based on historical paid claims, and the amount that would be included when hospital services are priced according to the existing State Plan methodology but using 100 percent of the adjustment factors, including the capital reimbursement percentage, and full inflation subject to approval by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. § 438.6(c).

"State Plan" means the state plan for medical assistance under Title XIX (42 U.S.C. § 1396 et seq.) of the Social Security Act.

"Upper payment limit" means the amount equal to the maximum amount of payment for inpatient services for recipients of medical assistance services established in accordance with 42 C.F.R § 447.272 and outpatient services for recipients of medical assistance services pursuant to 42 CFR § 447.321.

B. There is hereby created in the state treasury a special nonreverting fund to be known as the Health Care Payment Rate Assessment Fund, referred to in this section as "the Fund." The Fund shall be established on the books of the Comptroller. All revenues collected or received as a result of imposition of a health care payment rate assessment on covered hospitals and any other such moneys, public or private, received for the administration of the health care payment assessment shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys deposited to the Fund shall be used solely for the nonfederal share of the cost of payment rate actions associated with the payment rate assessment as provided in the general appropriation act and the administrative costs of collecting the assessment and of implementing and operating the associated payment rate

actions. Such moneys shall be appropriated as provided in the general appropriation act. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Director of the Department of Medical Assistance Services.

2018, Sp. Sess. I, c. 2.

§ 32.1-331.03. Process for payment directly to nursing facility or ICF/MR.

The Department of Medical Assistance Services shall, to the extent permitted by federal law, implement a process for payment of the nursing facility or ICF/MR share of payments directly to the nursing facility or ICF/MR rather than to the hospice care provider for hospice services furnished to an individual who is a resident of a nursing facility or ICF/MR and who would be eligible under the Commonwealth's program of medical assistance for nursing facility services or services in an ICF/MR had he not elected hospice care. Payments made directly to a nursing facility or ICF/MR shall be the full amount that would be paid to the nursing facility or ICF/MR if the individual was not receiving hospice services, and shall not reflect any discount to such rates.

2019, c. 209.

Article 2 - MEDICAID NEW DRUG REVIEW ACT

§§ 32.1-331.1 through 32.1-331.5. Repealed.

Repealed by Acts 1992, c. 200.

Article 1 - General Provisions

§ 32.1-331.04. Personal care aides; orientation program.

A. The Department of Medical Assistance Services shall establish an orientation program for all personal care aides who provide self-directed services through the Medicaid program. The program shall have the following requirements:

1. Attendance shall be limited to personal care aides, consumers who utilize the services of personal care aides, home care workers' employers of record, and worker advocacy organizations that represent personal care aides;

2. Orientations shall be held in-person or online at least quarterly, and personal care aides shall be invited and encouraged to attend at least one such orientation per calendar year; and

3. The orientation curriculum shall include content addressing operational procedures and record-keeping, including pay and benefits; available assistance and resources; roles and responsibilities in self-direction; diversity and equity training; transparency and fraud; and worker rights and responsibilities.

B. The Department of Medical Assistance Services may, in its discretion, contract with another state agency to provide the orientation described in this section.

2021, Sp. Sess. I, c. 236.

§ 32.1-331.05. Coordinated specialty care; work group.

A. The Department shall establish a work group in coordination with the Department of Behavioral Health and Developmental Services to evaluate and make recommendations to improve approaches to early psychosis and mood disorder detection approaches, make program funding recommendations, and recommend a core set of standardized clinical and outcome measures. Early psychosis intervention includes services to youth and young adults who are determined to either be at a clinical high risk for psychosis or are experiencing a first episode of psychosis.

B. The work group shall include (i) a representative from the Bureau of Insurance; (ii) a representative from the Department of Health Professions; (iii) a representative from the Department of Behavioral Health and Developmental Services; (iv) a psychiatrist with working knowledge of first-episode psychosis and coordinated specialty care; (v) a mental health clinician with working knowledge of first-episode psychosis and coordinated specialty care; (vi) a support services specialist with experience in supported education and employment; (vii) a representative of a state, regional, or local mental health advocacy group as recommended by such group; (viii) an individual who has experienced psychosis or a family member of an individual who has experienced psychosis; and (ix) up to three representatives of health insurance issuers or managed care organizations operating in the Commonwealth as recommended by such issuers or organizations.

C. The work group shall develop a five-year strategic plan to accomplish the following objectives:

1. Enhance services to existing coordinated specialty care programs;

2. Expand early psychosis intervention in underserved areas of the Commonwealth;

3. Develop a strategy to identify and apply for funds from individual foundations and federal and state sources and disburse those funds; and

4. Develop a strategy to advance the goals and utilization of coordinated specialty care for Medicaid beneficiaries and individuals who are privately insured.

The strategic plan shall identify current coordinated specialty care programs in the Commonwealth and include information on how they are funded, how many individuals use the current programs, and the insurance status of the programs. As used in this section, "coordinated specialty care" means a team-based service provided to a person for treatment of first-episode psychosis that is composed of case management, family support and education, pharmacotherapy and medication management, individual and group psychotherapy, supported education and employment, coordination with primary care, and outreach and recruitment activities.

D. The work group shall meet to produce an initial five-year plan report to the General Assembly no later than November 1, 2022, and then provide annual updates to the five-year strategic plan beginning November 1, 2023.

2022, c. 621.

Article 3 - VIRGINIA MEDICAID DRUG FORMULARY AND COMPETITIVE PROCUREMENT OF DRUG PRODUCTS

§§ 32.1-331.6 through 32.1-331.11. Repealed.

Repealed by Acts 1992, c. 200.

Article 4 - MEDICAID PRIOR AUTHORIZATION ADVISORY COMMITTEE

§ 32.1-331.12. Definitions.

As used in this article:

"Board" means the Board of Medical Assistance Services.

"Committee" means the Medicaid Prior Authorization Advisory Committee established pursuant to this article.

"Department" means the Department of Medical Assistance Services.

"Director" means the Director of Medical Assistance Services.

"Drug" shall have the same meaning, unless the context otherwise dictates or the Board otherwise provides by regulation, as provided in the Drug Control Act (§ 54.1-3400 et seq.).

1993, c. 537.

§ 32.1-331.13. Medicaid Prior Authorization Advisory Committee; membership.

The Board shall amend the state plan and promulgate regulations to establish the Medicaid Prior Authorization Advisory Committee, composed of 11 members to be appointed by the Board. Five members shall be physicians, at least three of whom shall care for a significant number of Medicaid patients; four shall be pharmacists, two of whom shall be community pharmacists; one member shall be an individual receiving mental health services; and one member shall be a Medicaid recipient. A quorum for action of the Committee shall consist of six members. The members shall serve at the pleasure of the Board, and vacancies shall be filled in the same manner as the original appointment. The Board shall consider nominations made by The Medical Society of Virginia, the Old Dominion Medical Society, the Psychiatric Society of Virginia, the Virginia Pharmaceutical Association, the National Alliance on Mental Illness of Virginia and the Virginia Mental Health Consumers Association when making appointments to the Committee.

The Committee shall elect its own officers, establish its own procedural rules, and meet as needed or as called by the Board, the Director, or any two members of the Committee. The Department shall provide appropriate staffing to the Committee.

1993, c. 537; 1996, c. 515; 2012, cc. 476, 507.

§ 32.1-331.14. Duties of the Committee.

A. The Committee shall make recommendations to the Board regarding drugs or categories of drugs to be subject to prior authorization and prior authorization requirements for prescription drug coverage

under the state plan, as well as any subsequent amendments to or revisions of such prior authorization requirements from time to time. The Board may accept or reject such recommendations in whole or in part, and may amend or add to such recommendations, except that the Board may not add to the recommendation of drugs and categories of drugs to be subject to prior authorization.

B. In formulating its recommendations to the Board, the Committee shall not be deemed to be formulating regulations for the purposes of the Administrative Process Act (§ 2.2-4000 et seq.). The Committee shall, however, conduct public hearings prior to making such recommendations to the Board. The Committee shall give thirty days' written notice by mail of the time and place of its hearings and meetings to any manufacturer whose product is being reviewed by the Committee and to those manufacturers who request the Committee in writing that they be informed of such hearings and meetings. Such persons shall be afforded a reasonable opportunity to be heard and present information. In addition, the Committee shall give thirty days' notice of such public hearings to the public by publishing its intention to conduct hearings and meetings in the Calendar of Events of the Virginia Register of Regulations and a newspaper of general circulation located in Richmond.

C. In acting on the recommendations of the Committee, the Board shall be required to conduct further proceedings under the Administrative Process Act.

1993, c. 537.

§ 32.1-331.15. Prior authorization of prescription drug products; coverage under state plan.

A. The Committee shall review prescription drug products to recommend prior authorization under the state plan in accordance with this article and regulations promulgated by the Board. Such review may be initiated by the Director, the Committee itself, or by written request of the Board. The Committee shall complete its recommendations to the Board within no more than six months from receipt of any such request.

B. Coverage under the state plan for any drug requiring prior authorization shall not be approved unless the prescriber obtains prior approval of such use in accordance with regulations promulgated by the Board and procedures established by the Department.

In formulating its recommendations to the Board, the Committee shall consider the potential impact on patient care and the potential fiscal impact of prior authorization on pharmacy, prescriber, hospitalization and outpatient costs. Any proposed regulation making a drug or category of drugs subject to prior authorization shall be accompanied by a statement of the estimated impact of such action on pharmacy, prescriber, hospitalization and outpatient costs.

C. The Committee shall not review any drug for which it has recommended or the Board has required prior authorization within the previous 12 months, unless new or previously unavailable relevant and objective information is presented.

D. Confidential proprietary information identified as such by a manufacturer or supplier in writing in advance and furnished to the Committee or the Board pursuant to this article shall not be subject to

the disclosure requirements of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.). The Board shall establish by regulation the means by which such confidential proprietary information shall be protected.

1993, c. 537; 2004, c. 855.

§ 32.1-331.16. Immunity.

The members of the Committee and of the Board, as well as the staff of the Department, shall be immune, individually and jointly, from civil liability for any act, decision, or omission done or made in performance of their duties pursuant to this article while serving as a member of such Board, Committee, or staff provided that such act, decision, or omission is not done or made in bad faith or with malicious intent.

1993, c. 537.

§ 32.1-331.17. Annual report to Joint Commission.

The Committee shall report annually to the Joint Commission on Health Care regarding its recommendations for prior authorization of drug products.

1993, c. 537.

Chapter 11 - VIRGINIA INDIGENT HEALTH CARE TRUST FUND [Repealed]

§§ 32.1-332 through 32.1-342. Repealed.

Repealed by Acts 2009, c. 578, cl. 2.

Chapter 12 - STATE/LOCAL HOSPITALIZATION PROGRAM

§ 32.1-343. Definitions.

As used in this chapter unless the context requires a different meaning:

"Board" means the Board of Medical Assistance Services.

"Director" means the Director of the Department of Medical Assistance Services.

"Indigent person" means a person who is a bona fide resident of the county or city, whether gainfully employed or not and who, either by himself or by those upon whom he is dependent, is unable to pay for required hospitalization or treatment. Residence shall not be established for the purpose of obtaining the benefits of this chapter. Migrant workers and aliens living in the United States illegally shall not be considered bona fide residents of the county or city for purposes of the State/Local Hospitalization Program.

1989, cc. 657, 746.

§ 32.1-344. State/Local Hospitalization Program.

There is hereby established within the Department of Medical Assistance Services the State/Local Hospitalization Program for indigent persons. With such funds as are appropriated for this purpose,

the Director of the Department of Medical Assistance Services is authorized to administer this program and to expend state and local funds in accordance with the provisions of this chapter.

1989, cc. 657, 746.

§ 32.1-345. Counties and cities required to participate; allocation and payment of funds to and payments by counties and cities.

A. The governing body of each city and county in the Commonwealth shall participate in the State/Local Hospitalization Program for indigent persons established in this chapter.

B. The Director shall allocate annually to the counties and cities of the Commonwealth such funds as may be appropriated by the General Assembly for this program. The allocation of state funds shall be based on the estimated total cost of required services in each county and city less the funds which shall be provided by the counties and cities.

C. Each county and city shall provide funds for a share of the estimated total costs as determined by the Director. The share for each county and city shall be calculated by dividing its per capita revenue capacity by the statewide total per capita revenue capacity, as determined by the Commission on Local Government, and by multiplying the resulting ratio by an aggregate local share of twenty-five percent. Each local share shall be adjusted according to local income, as determined by dividing the median adjusted gross income for all state income tax returns in each county and city by the median adjusted gross income for all income tax returns statewide. However, no county or city shall contribute more than twenty-five percent to the total cost for providing required hospitalization and treatment for indigent persons. The Director of Medical Assistance Services shall report each year by December 1 to the Senate Committees on Education and Health and on Finance and Appropriations and the House Committees on Health, Welfare and Institutions and Appropriations on the estimates of the costs of the program, based on trend analyses of the estimated costs of the actual local per capita demand.

D. Upon allocation of funds appropriated pursuant to subsection B of this section, each city and county shall remit within thirty days to the Department the amount determined to be the local share pursuant to subsection C of this section.

1989, cc. 657, 746; 1996, cc. 782, 792.

§ 32.1-346. Director to establish standards; reimbursement of services.

A. The Director shall prescribe regulations setting forth the amount, duration and scope of medical services covered by the Program which shall be uniform in all localities. Such services shall consist only of inpatient and outpatient hospital services, services rendered in free-standing ambulatory surgical centers and local public health clinics by providers who have signed agreements to participate in the State/Local Hospitalization Program and are enrolled providers in the Medical Assistance Program. Services covered under the Program shall not exceed in amount, duration or scope those available to recipients of Medical Assistance Services as provided in the State Plan for Medical Assistance pur-

suant to Chapter 10 (§ 32.1-323 et seq.) of this title. Subject to the above, the Board may modify such coverage so long as uniformity of coverage is maintained throughout the Commonwealth.

B. Reimbursement for services under this Program shall be equal to that of the Medical Assistance Program pursuant to Chapter 10 of this title as follows:

1. The reimbursement rate per visit for outpatient hospital services shall be the same as that established by the Department of Medical Assistance Services for an intermediate office visit for an established patient;

2. The inpatient hospital reimbursement rate shall be consistent with the Medicaid inpatient rate methodology. However, no disproportionate share or medical education adjustment for SLH inpatient hospital reimbursement shall be provided;

3. Inpatient hospital stays for adults shall be limited to twenty-one days of covered hospitalization within sixty days for the same or similar diagnosis. The sixty day period shall begin with the initial hospital admission. Only twenty-one total medically necessary days shall be covered whether incurred for one or more hospital stays, in the same or multiple hospitals, during the sixty day period. Inpatient hospital admissions on Friday and Saturday shall not be covered except in cases of medical emergencies. Reimbursement of inpatient hospital days on behalf of individuals up to the age of twenty-one shall be for medically necessary stays in excess of twenty-one days as provided in the State Plan for Medical Assistance Services;

4. The hospital emergency room reimbursement rate per visit shall be the same as that rate established by the Department of Medical Assistance Services for an intermediate level, established patient emergency department visit; and

5. The outpatient surgical rate for hospitals and ambulatory surgical centers shall be the same as the rates established by the Department of Medical Assistance Services for the facility component for ambulatory surgical centers.

C. Procedures identified by the Department of Medical Assistance Services as outpatient surgical procedures shall be performed in an outpatient setting unless the inpatient care was medically necessary and outpatient surgery could not be safely performed, the surgical procedure was performed with other surgical procedures requiring inpatient admission or adequate outpatient facilities were not available.

D. Acceptance of payment for services by a provider under this Program shall constitute payment in full.

1989, cc. 657, 746; 1996, cc. 782, 792.

§ 32.1-347. Eligibility for Program; duty of the Department of Social Services and local welfare or social services agencies; data required.

A. The Board of Medical Assistance Services shall promulgate regulations to establish uniform eligibility criteria by defining those persons who will qualify for payment for medical care under the Program. Such criteria shall include, but not be limited to, the following:

1. To be eligible, a person shall have net countable income, determined in accordance with the Board of Medical Assistance Services' regulations, equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations, except that localities which in fiscal year 1989 used an income level higher than 100 percent of the federal nonfarm poverty level may continue to use the same income level; and

2. To be eligible, a person shall have net countable resources, determined in accordance with the Board of Medical Assistance Services' regulations, equal to or less than the then current resource standards of the federal Supplemental Security Income Program.

Further, as a condition of eligibility, the Department of Medical Assistance Services shall require all legally competent applicants and recipients to assign to the Commonwealth any and all rights to third party benefits, whether contractual or otherwise, including medical support or payments, to which the applicants and recipients may be entitled. All applicants and recipients shall also agree to cooperate with the Department in obtaining such third party benefits. Such an assignment shall not preclude a court from apportioning sums which would be subject to the provisions of § 8.01-66.9.

B. Eligibility under this Program shall be determined by the Department of Social Services through the local boards of welfare or social services upon application for assistance under this program from residents of such localities. The eligibility criteria established by the Board pursuant to this section shall be used in processing all such applications. The local departments of welfare or social services shall certify to the applicant and Department of Medical Assistance Services within thirty days of receipt of each application whether the person applying meets such criteria.

C. Administrative appeal of adverse eligibility decisions shall be conducted by the Department using the procedures applicable to applicants for Medicaid benefits under the State Plan for Medical Assistance pursuant to Chapter 10 (§ 32.1-323 et seq.) of this title.

D. The State/Local Hospitalization Program shall be established in the books of the Comptroller so as to segregate the amounts appropriated and the amounts contributed thereto by the localities. No portion of the State/Local Hospitalization Program shall be used for a purpose other than that described in this chapter. Any state funds remaining at the end of the fiscal year shall not revert to the general fund but shall remain in the State/Local Hospitalization Program to be used as an offset to the calculated local share for the following year. Any local share money remaining at the end of the fiscal year or the biennium shall remain in the locality's account under the State/Local Hospitalization Program to be used by the Department as an offset to the calculated local share for the following year.

1989, cc. 657, 746; 1992, c. 104; 1994, c. 297; 1996, cc. 782, 792.

§ 32.1-348. Applicability of chapter.

Nothing in this chapter shall be construed as relieving any hospital of its obligations under the Hill-Burton Act or any other similar federal or state law or agreement to provide unreimbursed care to indigent persons.

1989, cc. 657, 746.

§ 32.1-349. Liability for excess payments.

Any person who obtains benefits under this program to which he is not entitled shall be liable for any excess benefits received. If the recipient knew or reasonably should have known that he was not entitled to the excess benefits, he may also be liable for interest on the amount of the excess benefits at the judgment rate as defined in § 6.2-302 from the date upon which he knew or reasonably should have known that he had received excess benefits to the date on which repayment is made to the Commonwealth. No person shall be liable for payment of interest, however, when excess benefits were obtained as a result of errors made solely by the Department of Medical Assistance Services or any local welfare or social services agency.

Any payment erroneously made on behalf of a recipient or former recipient of this program may be recovered by the Department of Medical Assistance Services from the recipient or the recipient's income, assets or estate unless such property is otherwise exempted by state or federal law or regulation.

Any person who, on behalf of himself or another, obtains or attempts to obtain the benefits of this program by means of (i) willful false statement, (ii) willful misrepresentation or concealment of a material fact, or (iii) any other fraudulent scheme or device shall be liable for repayment of any excess benefits received, plus interest on the amount of the excess benefits at the rate of 1.5 percent per month for the period from the date upon which payment was made for such benefits to the date on which repayment is made to the Commonwealth.

All civil penalties collected pursuant to this section shall be deposited with the Comptroller for the State/Local Hospitalization Program in the same manner as the state and local shares.

1989, cc. 657, 746.

§ 32.1-350. Fraudulently obtaining benefits; criminal penalty.

A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of a Class 1 misdemeanor in addition to any other penalties provided by law:

1. Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact in an application for eligibility under this program or in order to participate in or receive reimbursement from the program;

2. Knowingly and willfully concealing or failing to disclose any event affecting the initial or continued right of any individual to any benefits with an intent to secure fraudulently such benefits in a greater amount or quantity than is authorized or when no such benefit is authorized;

3. Knowingly and willfully failing to notify the local department of social services, through whom the benefits of this program were obtained, of changes in the circumstances of any recipient or applicant which could result in reduction or termination of the benefits;

4. Knowingly and willfully failing to provide any reports or data to the Department as required in this chapter.

B. Conviction of any provider or any employee or officer of such provider of any offense under this section shall also result in forfeiture of any payments due.

1989, cc. 657, 746; 2002, c. 747.

Chapter 13 - Family Access to Medical Insurance Security Plan

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

A. The Department of Medical Assistance Services shall amend the Virginia Children's Medical Security Insurance Plan to be renamed the Family Access to Medical Insurance Security (FAMIS) Plan. The Department of Medical Assistance Services shall provide coverage under the Family Access to Medical Insurance Security Plan for individuals under the age of 19 when such individuals (i) have family incomes at or below 200 percent of the federal poverty level or were enrolled on the date of federal approval of Virginia's FAMIS Plan in the Children's Medical Security Insurance Plan (CMSIP); such individuals shall continue to be enrolled in FAMIS for so long as they continue to meet the eligibility requirements of CMSIP; (ii) are not eligible for medical assistance services pursuant to Title XIX of the Social Security Act, as amended; (iii) are not covered under a group health plan or under health insurance coverage, as defined in § 2791 of the Public Health Service Act (42 U.S.C. § 300gg-91 (a) and (b)(1)); and (iv) meet both the requirements of Title XXI of the Social Security Act, as amended, and the Family Access to Medical Insurance Security Plan. Eligible children, residing in Virginia, whose family income does not exceed 200 percent of the federal poverty level during the enrollment period shall receive 12 continuous months of coverage as permitted by Title XXI of the Social Security Act.

B. The Department of Medical Assistance Services shall also provide coverage for children and pregnant women who meet the criteria set forth in clauses (i) through (iv) of subsection A 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).

C. Family Access to Medical Insurance Security Plan participants shall participate in cost-sharing to the extent allowed under Title XXI of the Social Security Act, as amended, and as set forth in the Virginia Plan for Title XXI of the Social Security Act. The annual aggregate cost-sharing for all eligible children in a family above 150 percent of the federal poverty level shall not exceed five percent of the family's gross income or as allowed by federal law and regulations. The annual aggregate cost-sharing for all eligible children in a family at or below 150 percent of the federal poverty level shall not exceed 2.5 percent of the family's gross income. The nominal copayments for all eligible children in a family shall not be less than those in effect on January 1, 2003. Cost-sharing shall not be required for well-child and preventive services including age-appropriate child immunizations.

D. The Family Access to Medical Insurance Security Plan shall provide comprehensive health care benefits to program participants, including well-child and preventive services, to the extent required to comply with federal requirements of Title XXI of the Social Security Act. These benefits shall include comprehensive medical, dental, vision, mental health, and substance abuse services, and physical therapy, occupational therapy, speech-language pathology, and skilled nursing services for special

education students. The medical services required to be provided herein shall include dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time, in accordance with subdivision A 27 of § 32.1-325. The mental health services required herein shall include intensive in-home services, case management services, day treatment, and 24-hour emergency response. The services shall be provided in the same manner and with the same coverage and service limitations as they are provided to children under the State Plan for Medical Assistance Services.

E. The Virginia Plan for Title XXI of the Social Security Act shall include a provision that participants in the Family Access to Medical Insurance Security Plan who have access to employer-sponsored health insurance coverage, as defined in § 32.1-351.1, may, but shall not be required to, enroll in an employer's health plan, and the Department of Medical Assistance Services or its designee shall make premium payments to such employer's plan on behalf of eligible participants if the Department of Medical Assistance Services or its designee determines that such enrollment is cost-effective, as defined in § 32.1-351.1.

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

G. The health care benefits provided under the Family Access to Medical Insurance Security Plan shall be through existing Department of Medical Assistance Services' contracts with health maintenance organizations and other providers, or through new contracts with health maintenance organizations, health insurance plans, other similarly licensed entities, or other entities as deemed appropriate by the Department of Medical Assistance Services, or through employer-sponsored health insurance. All eligible individuals, insofar as feasible, shall be enrolled in health maintenance organizations.

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

I. The Virginia Plan for Title XXI of the Social Security Act, as amended, shall include a provision that, in addition to any centralized processing site, local social services agencies shall provide and accept applications for the Family Access to Medical Insurance Security Plan and shall assist families in the completion of applications. Contracting health plans, providers, and others may also provide applications for the Family Access to Medical Insurance Security Plan and may assist families in completion of the applications.

J. The Department of Medical Assistance Services shall develop and submit to the federal Secretary of Health and Human Services an amended Title XXI plan for the Family Access to Medical Insurance Security Plan and may revise such plan as may be necessary. Such plan and any subsequent revisions shall comply with the requirements of federal law, this chapter, and any conditions set forth in the appropriation act. In addition, the plan shall provide for coordinated implementation of publicity, enrollment, and service delivery with existing local programs throughout the Commonwealth that provide health care services, educational services, and case management services to children. In developing and revising the plan, the Department of Medical Assistance Services shall advise and consult with the Joint Commission on Health Care.

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

L. The Board of Medical Assistance Services, or the Director, as the case may be, shall adopt, promulgate, and enforce such regulations pursuant to the Administrative Process Act (§ 2.2-4000 et seq.) as may be necessary for the implementation and administration of the Family Access to Medical Insurance Security Plan.

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

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

O. In addition, in any case in which any provision set forth in Title 38.2 excludes, exempts or does not apply to the Virginia plan for medical assistance services established pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), such exclusion, exemption or carve out of application to Title XIX of the Social Security Act (Medicaid) shall be deemed to subsume and thus to include the Family Access to Medical Insurance Security (FAMIS) Plan, established pursuant to Title

XXI of the Social Security Act, upon approval of FAMIS by the federal Centers for Medicare & Medicaid Services as Virginia's State Children's Health Insurance Program.

1997, c. 679; 1999, c. 1034; 2000, cc. 824, 848; 2001, cc. 238, 735, 756; 2002, c. 640; 2003, cc. 66, 71, 521; 2005, c. 584; 2006, c. 428; 2007, c. 407; 2012, cc. 646, 689; 2014, cc. 9, 183; 2021, Sp. Sess. I, c. 245.

§ 32.1-351.1. Assistance with employer-sponsored health insurance.

A. For purposes of this chapter, "employer-sponsored health insurance" or "ESHI" means comprehensive health insurance offered by the employer when the employer contributes to the cost of dependent or family coverage as defined in the Virginia Plan for Title XXI of the Social Security Act, or as otherwise approved by the Centers for Medicare & Medicaid Services in the U.S. Department of Health and Human Services.

B. For purposes of this chapter, ESHI shall be deemed cost-effective when the payment by the Department of Medical Assistance Services for health insurance coverage of the enrollee or enrollees under the Family Access to Medical Insurance Security Plan shall be no greater than what would have otherwise been paid by the Department or its designee for the enrollee or enrollees.

C. If a family chooses to participate in ESHI and ESHI is deemed cost-effective, the Department of Medical Assistance Services shall contribute to the cost of ESHI for eligible dependent children for those program participants that have access to ESHI. Participants receiving ESHI under the Family Access to Medical Insurance Security Plan shall apply for the full premium contribution available from the employer. Those eligible for Family Access to Medical Insurance Security Plan with access to ESHI may enroll in their designated ESHI at the first available opportunity and shall be covered under the Family Access to Medical Insurance Security Plan until coverage under ESHI becomes available.

2000, cc. 824, 848; 2003, c. 513; 2009, c. 578.

§ 32.1-351.2. Children's Health Insurance Program Advisory Committee; purpose; membership; etc.

The Department of Medical Assistance Services shall maintain a Children's Health Insurance Program Advisory Committee to assess the policies, operations, and outreach efforts for Family Access to Medical Insurance Security (FAMIS) and FAMIS Plus and to evaluate enrollment, utilization of services, and the health outcomes of children eligible for such programs. The Committee shall consist of no more than 20 members and shall include membership from appropriate entities, as follows: one representative of the Joint Commission on Health Care, the Department of Social Services, the Department of Health, the Department of Education, the Department of Behavioral Health and Developmental Services, the Virginia Health Care Foundation, various provider associations and children's advocacy groups; and other individuals with significant knowledge and interest in children's health insurance. The Committee may report on the current status of FAMIS and FAMIS Plus and make recommendations as deemed necessary to the Director of the Department of Medical Assistance Services and the Secretary of Health and Human Resources.

The Department of Medical Assistance Services shall enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced price school lunches or for services through the Women, Infants, and Children program (WIC) in order that the eligibility of such children for the Virginia Plan for Title XXI of the Social Security Act may be determined expeditiously.

2000, cc. 824, 848; 2002, c. 329; 2004, c. 301; 2009, cc. 813, 840.

§ 32.1-352. Virginia Family Access to Medical Insurance Security Plan Trust Fund.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Family Access to Medical Insurance Security Plan Trust Fund, hereinafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. The Fund shall consist of the premium differential, any and all employer contributions which may be solicited or received by the Department of Medical Assistance Services, grants, donations, gifts, and bequests, or any and all moneys designated for the Fund, from any source, public or private. As used in this section, "premium differential" means an amount equal to the difference between (i) 0.75 percent of the direct gross subscriber fee income derived from eligible contracts and (ii) the amount of license tax revenue generated pursuant to former subdivision A 4 of § 58.1-2501 with respect to eligible contracts. As used in this section, "eligible contract" means any subscription contract for any kind of plan classified and defined in § 38.2-4201 or 38.2-4501 issued other than to (i) an individual or (ii) a primary small group employer if income from the contract is subject to license tax at the rate of 2.25 percent pursuant to former subsection D of § 38.2-4229.1. The Department of Taxation shall annually, on or before June 30, calculate the premium differential for the immediately preceding taxable year and notify the Comptroller of the Commonwealth to transfer such amount to the Virginia Family Access to Medical Insurance Security Plan Trust Fund as established on the books of the Comptroller.

B. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely to support the Virginia Family Access to Medical Insurance Security Plan in accordance with the requirements of Title XXI of the Social Security Act, as amended, the Commonwealth's plan for the State Children's Health Insurance Program (SCHIP), as established in Subtitle J of the federal Balanced Budget Act of 1997 (P. L. 105-33), and any conditions set forth in the appropriation act.

C. The Director of the Department of Medical Assistance Services shall report annually on December 1 to the Governor, the General Assembly, and the Joint Commission on Health Care on the status of the Fund, the number of children served by this program, the costs of such services, and any issues related to the Virginia Family Access to Medical Insurance Security Plan that may need to be addressed.

1997, c. 679; 1999, c. 1034; 2000, cc. 824, 848; 2011, c. 850; 2013, cc. 136, 210.

§ 32.1-353. Rights and responsibilities.

This chapter shall not be construed as creating any legally enforceable right or entitlement to benefits under the Family Access to Medical Insurance Security Plan under Title XXI of the Social Security Act, as amended, on the part of any person or any right or entitlement to participation. The Department of Medical Assistance Services shall enroll applicants into the Family Access to Medical Insurance Security Plan under Title XXI to the extent funds are made available or as directed by the appropriation act. The Family Access to Medical Insurance Security Plan and any benefits provided thereunder shall not be assistance or public assistance pursuant to Chapter 5 (§ 63.2-500 et seq.) of Title 63.2.

1997, c. 679; 2000, cc. 824, 848.

Chapter 13.1 - CERTIFIED NURSING FACILITY EDUCATION INITIATIVE

§ 32.1-353.1. Certified nursing facility education initiative; purpose.

The General Assembly finds that early identification of potential certified nursing facility deficiencies, coupled with the opportunity to correct any such problems, will improve quality of care and life to certified nursing facility residents in the Commonwealth. In order to implement the General Assembly's finding, early on-site training and assistance shall be provided to certified nursing facilities that are found not in substantial compliance with long-term care requirements and that meet certain requirements as set forth in the Nursing Facility Quality Improvement Program developed pursuant to § 32.1-353.3.

Creative and innovative approaches to the provision of long-term care services may also be explored. Such measures can best be accomplished by using the data, expertise, and knowledge of representatives of state government and representatives from the consumer, long-term care provider, and business communities. For this reason, the Board of Medical Assistance Services, assisted by the Department of Medical Assistance Services, shall administer the education initiatives for certified nursing facility care established by this chapter.

2000, c. 475; 2003, c. 481; 2007, c. 474.

§ 32.1-353.2. Definitions.

As used in this chapter:

"Board" means the Board of Medical Assistance Services.

"Certified nursing facility" means any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified for participation as a Medicare or Medicaid provider, or both, pursuant to Title XVIII and Title XIX of the United States Social Security Act, as amended, and § 32.1-137.

"Civil money penalty funds" means those funds collected by the Department of Medical Assistance Services for enforcement of certified nursing facility remedies pursuant to Title XIX of the Social Security Act.

"Director" means the Director of the Department of Medical Assistance Services.

2000, c. 475; 2003, c. 481; 2007, c. 474.

§ 32.1-353.3. Authorization to expend civil money penalty funds.

A. The Department of Medical Assistance Services, as administrator of the state Medicaid program, maintains a fund comprised of civil money penalties received from nursing facilities as a result of enforcement of federal survey requirements. Pursuant to federal regulations, such funds shall be used for the protection of the health or property of certified nursing facility residents.

B. In addition to the remedies specified in subsection A, the Director shall establish a Nursing Facility Quality Improvement Program in compliance with all applicable federal and state regulations designed to improve the health, safety, and welfare of residents in nursing facilities. The Director shall develop the Nursing Facility Quality Improvement Program in cooperation with affected state agencies, representatives of the nursing facility provider community, and advocacy groups.

2000, c. 475; 2003, c. 481; 2007, c. 474.

§§ 32.1-353.4 , 32.1-353.5. Repealed.

Repealed by Acts 2007, c. 474, cl. 2.

§ 32.1-353.6. Repealed.

Repealed by Acts 2003, c. 481, cl. 2.

Chapter 14 - VIRGINIA FOUNDATION FOR HEALTHY YOUTH

§ 32.1-354. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

"Agreement" means the agreement or agreements between the Commonwealth, as seller of the Tobacco Assets, and the Corporation, as purchaser of the Tobacco Assets. The sale by the Commonwealth of the Tobacco Assets pursuant to any such agreement shall be a true sale and not a borrowing.

"Board" means the Board of Trustees of the Foundation appointed pursuant to § 32.1-357.

"Corporation" means the Tobacco Settlement Financing Corporation as created under state law.

"Director" means the director of the Foundation appointed pursuant to § 32.1-358.

"Endowment" means the Virginia Tobacco Settlement Foundation Endowment established pursuant to § 32.1-361.1.

"Foundation" means the Virginia Foundation for Healthy Youth, created pursuant to § 32.1-355.

"Foundation Allocation" means 10 percent of the annual amount received under the Master Settlement Agreement by the Commonwealth, or that would have been received but for the sale of such allocation pursuant to an agreement, between the starting and ending dates specified in the agreement.

"Fund" means the Virginia Tobacco Settlement Fund established pursuant to § 32.1-360.

"Period of sale" means the time during which a purchase under an agreement is entitled to receive the Foundation Allocation.

"Tobacco Assets" means all right, title, and interest in and to the portion of the Foundation Allocation that may be sold to the Corporation from time to time.

1999, cc. 880, 962; 2007, c. 345; 2009, cc. 424, 554.

§ 32.1-355. Virginia Foundation for Healthy Youth created; purposes.

A. The Virginia Foundation for Healthy Youth (VFHY) is hereby created as a body corporate and a political subdivision of the Commonwealth and as such shall have, and is hereby vested with, all of the politic and corporate powers as are set forth in this chapter. The Foundation is established for the purposes of determining the appropriate recipients of moneys in the Virginia Tobacco Settlement Fund and causing distribution of such moneys for the purposes provided in this chapter.

B. The Foundation shall include the following divisions:

1. The Virginia Tobacco Settlement Foundation (VTSF) division, to assist in financing efforts to restrict the use of tobacco products by minors through such means as educational and awareness programs on the health effects of tobacco use on minors and enforcement of laws restricting the distribution of tobacco products to minors;

2. The Virginia Youth Obesity Prevention (VYOP) division, which may use moneys from the Fund to assist in financing efforts to reduce childhood obesity through such means as educational and awareness programs, implementing evidence-based practices, and assisting schools and communities with policies and programs; and

3. The Virginia Youth Substance Use Prevention (VYSUP) division, which may use moneys from the Fund to assist in financing efforts to prevent and reduce substance use by youth in the Commonwealth through such means as educational and awareness programs, implementing evidence-based practices, and assisting schools and communities with policies and programs.

C. The Foundation shall have only those powers enumerated in § 32.1-356.

1999, cc. 880, 962; 2009, cc. 424, 554; 2017, cc. 60, 109.

§ 32.1-356. Powers of the Foundation.

The Foundation is hereby granted all powers necessary or appropriate to carry out and effectuate its corporate purposes, including, without limitation, the following:

1. To have official seals and to alter the same at pleasure;

2. To maintain an office at such place or places within this Commonwealth as it may designate;

3. To accept, hold, and administer moneys, grants, securities, or other property transferred, given, or bequeathed to the Foundation, absolutely or in trust, for the purposes for which the Foundation is created;

4. To determine how moneys in the Fund are to be distributed and to authorize distribution of moneys in the Fund to entities whose goal is to discourage, eliminate or prevent the use of tobacco products by minors, reduce childhood obesity in the Commonwealth, or prevent and reduce substance use by youth in the Commonwealth, on such terms and in such amounts as determined by the Board;

5. To deposit moneys from the Fund to the Endowment as determined by the Board;

6. To make and execute contracts and all other instruments and agreements necessary or convenient for the exercise of its powers and functions;

7. To appoint and prescribe the duties of such officers, agents, employees, advisors, and consultants as may be necessary to carry out its functions, and to fix and pay such compensation to them for their services as the Foundation may determine;

8. To adopt and from time to time amend and repeal bylaws, not inconsistent with this chapter, to carry into effect the powers and purposes of the Foundation;

9. To receive and accept aid, grants, contributions and cooperation of any kind from any source for the purposes of this chapter subject to such conditions, acceptable to the Foundation, upon which such aid, grants, contributions and cooperation may be made;

10. To do any lawful act necessary or appropriate to carry out the powers herein granted or reasonably implied, including use of whatever lawful means may be necessary and appropriate to recover any payments wrongfully made from the Fund.

1999, cc. 880, 962; 2007, c. 345; 2009, cc. 424, 554; 2017, cc. 60, 109.

§ 32.1-357. Board of Trustees; appointment; officers; quorum; executive committee; compensation and expenses.

A. The Foundation shall be governed and administered by a Board of Trustees consisting of 23 members. Two members shall be appointed by the Speaker of the House of Delegates from among the membership of the House of Delegates, one representing rural interests and one representing urban interests; two members shall be appointed by the Senate Committee on Rules, one representing rural interests and one representing urban interests, from among the membership of the Senate; two members shall be the Commissioner of the Department of Health or his designee and the Chairman of the Board of Directors of the Virginia Alcoholic Beverage Control Authority or his designee; and 17 nonlegislative citizen members shall be appointed by the Governor, subject to confirmation by the General Assembly, as follows: (i) five designated representatives of public health organizations, such as the American Cancer Society, American Heart Association, Virginia Pediatric Society, Virginia Academy of Family Physicians, Virginia Dental Association, American Lung Association of Virginia, Medical Society of Virginia, Virginia Association of School Nurses, Virginia Nurses Association, and the Virginia Thoracic Society; (ii) four health professionals in the fields of oncology, cardiology, pulmonary medicine, and pediatrics; and (iii) eight citizens at large, including two youths. Of the eight citizen at large members, three adults shall be appointed by the Governor from a list of six provided by members

of the General Assembly appointed to the Foundation and one member who is under the age of 18 years shall be appointed by the Governor from a list of three provided by the members of the General Assembly appointed to the Foundation.

Legislative members and the Commissioner of the Department of Health and the Chairman of the Board of Directors of the Virginia Alcoholic Beverage Control Authority shall serve terms coincident with their terms of office. Following the initial staggering of terms, nonlegislative citizen members shall serve four-year terms. Vacancies in the membership of the Board shall be filled by appointment for the unexpired portion of the term. Vacancies shall be filled in the same manner as the original appointments. Legislative members may be reappointed for successive terms. No nonlegislative citizen member shall be eligible to serve for more than two successive four-year terms; however, after the expiration of a term of three years or less, or after the expiration of the remainder of a term to which he was appointed to fill a vacancy, two additional terms may be served by such member if appointed thereto. Immediately after such appointment, the members shall enter upon the performance of their duties.

B. The Foundation shall appoint from the membership of the Board a chairman and vice-chairman, both of whom shall serve in such capacities at the pleasure of the Foundation. The chairman, or in his absence, the vice-chairman, shall preside at all meetings of the Board. A majority of the members of the Board serving at any one time shall constitute a quorum for the transaction of business. The Board shall meet annually or more frequently at the call of the chairman.

The Board may establish an executive committee composed of the chairman, vice-chairman, and three additional members elected by the Board from its membership. The chairman of the Board shall serve as the chairman of the executive committee and shall preside over its meetings. In the absence of the chairman, the vice-chairman shall preside. The executive committee may exercise the powers and transact the business of the Board in the absence of the Board or when otherwise directed or authorized by the Board. A majority of the members of the executive committee shall constitute a quorum for the transaction of business. Any actions or business conducted by the executive committee shall be acted upon by the full board as soon as practicable.

C. Legislative members shall receive such compensation as provided in § 30-19.12 and nonlegislative citizen members shall receive compensation as provided in § 2.2-2813 for their services. All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided by §§ 2.2-2813 and 2.2-2825. Such compensation and expenses shall be paid from the Fund.

D. Notwithstanding the provisions of any other law, no officer or employee of the Commonwealth shall be deemed to have forfeited or shall forfeit his office or employment by reason of his acceptance of membership on the Board or his service to the Foundation.

E. Members of the Board and employees of the Foundation shall be subject to the standards of conduct set forth in the State and Local Government Conflict of Interests Act (§ 2.2-3100 et seq.) and may

be removed from office for misfeasance, malfeasance, nonfeasance, neglect of duty, or misconduct in the manner set forth therein.

1999, cc. 880, 962; 2000, c. 1067; 2004, c. 1000; 2005, c. 19; 2015, cc. 38, 730.

§ 32.1-358. Appointment of director; counsel to the Board and Foundation.

A. Subject to confirmation by the General Assembly, the Governor shall appoint a director, whose compensation shall be determined by the Board, subject to approval by the Governor, and who shall also be the secretary of the Board. The director shall administer, manage and direct the affairs and business of the Foundation in accordance with the provisions of this chapter, subject to the policies, control and direction of the Board. The Board may employ technical experts and such other officers, agents and employees, permanent and temporary, as it may require, and shall determine their qualifications, duties and compensation. The Board may delegate to one or more of its agents or employees such administrative duties as it may deem proper. The actual expenses incurred in the performance of such duties shall be paid from the Fund.

B. The Office of the Attorney General shall provide counsel to the Board and the Foundation.

1999, cc. 880, 962; 2000, c. 1067.

§ 32.1-359. Duties of the Board.

The Board shall perform the following duties:

1. Establish specific criteria and procedures governing decisions by the Foundation to cause the moneys obtained from the Master Settlement Agreement in the Fund to be primarily distributed to entities for use in the discouragement, elimination or prevention of the use of tobacco products by minors. Additionally, the Foundation may distribute moneys in the Fund obtained primarily from public grants and private funding sources to reduce childhood obesity and to prevent and reduce substance use by youth in the Commonwealth;

2. Establish requirements that every recipient of money distributed from the Fund establish and maintain policies that restrict the use of tobacco products by minors, as provided in § 32.1-361;

3. Evaluate the proposals for the use of the assets of the Fund in accordance with the criteria established by the Board and the provisions of this chapter;

4. Evaluate the implementation and results of all efforts receiving support from the Foundation; and

5. Determine amounts to be deposited from time to time from the Fund to the Endowment.

1999, cc. 880, 962; 2007, c. 345; 2009, cc. 424, 554; 2017, cc. 60, 109.

§ 32.1-360. Virginia Tobacco Settlement Fund.

There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Tobacco Settlement Fund. The Fund shall be established on the books of the Comptroller. Subject to the sale of all or any portion of the Foundation Allocation, 10 percent of the annual amount received by the Commonwealth from the Master Settlement Agreement shall be paid into the state treasury and

credited to the Fund. In the event of such sale (i) the Foundation Allocation shall be paid in accordance with the agreement for the period of sale and (ii) the fund shall receive amounts withdrawn from the Endowment in accordance with § 32.1-361.1. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes described in this chapter. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written authorization signed by the chairman of the Board or his designee. Moneys in the Fund shall be used for the purposes of (a) discouraging, eliminating or preventing the use of tobacco products by minors, including but not limited to, educational and awareness programs on the health effects of tobacco use on minors and laws restricting the distribution of tobacco products to minors; (b) reducing childhood obesity, including but not limited to educational and awareness programs, implementing evidence-based practices, and assisting schools and communities with related policies and programs; and (c) preventing and reducing substance use by youth in the Commonwealth, including but not limited to educational and awareness programs, implementing evidence-based practices, and assisting schools and communities with related policies and programs.

1999, cc. 880, 962; 2007, c. 345; 2009, cc. 424, 554; 2017, cc. 60, 109.

§ 32.1-361. Use of moneys distributed.

Any recipient of any moneys distributed from the Fund pursuant to this chapter shall be required, as a condition precedent to the release of such moneys to such entity, to establish and maintain policies restricting or preventing tobacco use by minors. The Foundation shall (i) establish criteria for determining whether an entity's policies support the restriction of tobacco use by minors and (ii) monitor the distribution of such moneys to ensure that the recipients of such funds are in compliance with the provisions of this section.

1999, cc. 880, 962; 2009, cc. 424, 554.

§ 32.1-361.1. Virginia Foundation for Healthy Youth Endowment.

A. There is hereby established in the state treasury a special fund to be designated the "Virginia Foundation for Healthy Youth Endowment" (the Endowment). The Endowment shall receive any proceeds from any sale of all or any portion of the Foundation Allocation, deposits from the Fund as determined by the Board pursuant to subdivision 5 of § 32.1-356, and any gifts, grants, and contributions that are specifically designated for inclusion in such Endowment. No part of the Endowment, neither corpus nor income, or interest thereon, shall revert to the general fund of the state treasury. The Endowment shall be under the management and control of the Treasury Board and the Treasury Board shall have such powers and authority as may be necessary to exercise such management and control consistent with the provisions of this section. The income of the Endowment shall be paid out, not less than annually, to the Fund. In addition, up to 10 percent of the corpus of the Endowment shall be paid to the Fund annually upon request of the Board to the Treasury Board; provided, however, that upon two-thirds vote of the Board, up to 15 percent of the corpus of the Endowment shall be so paid.

No use of proceeds shall be made that would cause bonds issued on a tax-exempt basis to be considered taxable. For purposes of this section, "income" of the Endowment means at the time of determination the lesser of the available cash in, or the realized investment income for the applicable period of the Endowment, and "corpus" of the endowment means at the time of determination the sum of the proceeds from the sale of all or any portion of the Foundation Allocation, deposits from the Fund as determined by the Board pursuant to subdivision 5 of § 32.1-356, any gifts, grants, and contributions that have been credited to such Endowment, and any income not appropriated and withdrawn from the Endowment before June 30 of each year, less withdrawals from the corpus. Determinations by the Treasury Board, or the State Treasurer on behalf of the Treasury Board, as to the amount of income or the amount of the corpus shall be conclusive.

B. The Treasury Board shall serve as trustee of the Endowment and the corpus and income of the Endowment shall be withdrawn and credited to the Fund by order of the Treasury Board as provided in subsection A. The State Treasurer shall be custodian of the funds credited to the Endowment. The Treasury Board shall have full power to invest and reinvest funds credited to the Endowment in accordance with the provisions of the Uniform Prudent Management of Institutional Funds Act (§ 64.2-1100 et seq.) and, in addition, as otherwise provided by law. The Treasury Board may borrow money in such amounts as may be necessary whenever in its judgment it would be more advantageous to borrow money than to sell securities held for the Fund. Any debt so incurred may be evidenced by notes duly authorized by resolution of the Treasury Board, such notes to be retired no later than the end of the biennium in which such debt is incurred. The Treasury Board may commingle, for purposes of investment, the corpus of the Endowment provided that it shall appropriately account for the investments credited to the Endowment. The Treasury Board may hire independent investment advisors and managers as it deems appropriate to assist with investing the Endowment. The expenses of making and disposing of investments, such as brokerage commissions, legal expenses related to a particular transaction, investment advisory and management fees and expenses, transfer taxes and other customary transactional expenses shall be payable out of the income of the Endowment.

C. Not less than annually and more frequently if desired by the Board or requested by the Treasury Board, the Board shall provide to the Treasury Board schedules of anticipated disbursements from the Fund for the current and succeeding fiscal year, and the Treasury Board shall, to the extent practicable, take into account such schedules and changes thereto in scheduling maturities and redemptions of its investments of the Endowment.

2007, c. 345; 2008, c. 184; 2009, cc. 424, 554.

§ 32.1-362. Audit.

The accounts of the Foundation shall be audited by the Auditor of Public Accounts, or his legally authorized representatives, as determined necessary by the Auditor of Public Accounts. Copies of the audit shall be distributed to the Governor and to the Chairmen of the House Committee on Appropriations and the Senate Committee on Finance and Appropriations.

1999, cc. 880, 962; 2018, cc. 57, 307.

§ 32.1-363. Forms of accounts and records.

The accounts and records of the Foundation showing the receipt and disbursement of funds from whatever source derived shall be in such form as the Auditor of Public Accounts prescribes.

1999, cc. 880, 962.

§ 32.1-364. Reports to the Governor and General Assembly.

The Foundation shall submit a report no later than March 31 of each year to the Governor and the General Assembly. The report shall include information regarding programs supported by the Foundation and expenditures from the Fund.

1999, cc. 880, 962; 2005, c. 19.

§ 32.1-365. Public purpose; exemption from taxation.

A. The exercise of the powers granted by this chapter shall be in all respects for the benefit of the citizens of the Commonwealth and for the promotion of their safety, health, welfare, knowledge, convenience and prosperity.

B. The Foundation will be performing an essential governmental function in the exercise of the powers conferred upon it by this chapter, and the property of the Foundation and its income and operations shall be exempt from taxation or assessments upon any property acquired or used by the Foundation under the provisions of this chapter.

1999, cc. 880, 962.

Chapter 15 - VIRGINIA HEALTH CARE FUND

§ 32.1-366. Virginia Health Care Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Virginia Health Care Fund, hereafter referred to as the "Fund." The Fund shall be established on the books of the Comptroller and any moneys remaining in the Fund at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. For purposes of the Comptroller's preliminary and final annual reports required by § 2.2-813, however, all deposits to and disbursements from the Fund shall be accounted for as part of the general fund of the state treasury.

B. All revenue received by the Commonwealth pursuant to the provisions of (i) §§ 58.1-1001 and 58.1-1018, (ii) Article 2.1 (§ 58.1-1021.01 et seq.) of Chapter 10 of Title 58.1, and (iii) § 3.2-4203 shall be paid into the state treasury and deposited to the Fund. The Comptroller shall also deposit 40 percent of the Commonwealth's allocation pursuant to the Master Settlement Agreement with tobacco product manufacturers, as defined in § 3.2-3100, to the Fund. The Fund shall also consist of all recoveries received during a fiscal year resulting from expenditures incurred in the Medicaid program during a prior fiscal year or years to the extent that such amounts represent recoveries of state funds that would otherwise be deposited to the general fund of the state treasury.

2004, Sp. Sess. I, c. 3; 2005, cc. 899, 901.

§ 32.1-367. Uses of Virginia Health Care Fund.

Moneys deposited to the Fund shall be used solely for the provision of health care services. Such moneys shall be appropriated as provided in the general appropriation act. Health care services include, but are not limited to, Medicaid payments, disease diagnosis, prevention and control, and community health services.

2004, Sp. Sess. I, c. 3.

Chapter 16 - BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT FUND

§ 32.1-368. Breast and Cervical Cancer Prevention and Treatment Fund established.

A. There is hereby created in the state treasury a special nonreverting fund to be known as the Breast and Cervical Cancer Prevention and Treatment Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller and shall be administered by the Director of the Department of Medical Assistance Services. Any moneys remaining in the Fund at the end of each fiscal year, including interest earned thereon, shall not revert to the general fund but shall remain in the Fund.

B. The Fund shall consist solely of (i) revenues received by the Commonwealth from voluntary contributions of tax refunds pursuant to the provisions of § 58.1-344.3 that are paid into the state treasury and deposited to the Fund, (ii) specifically designated federal funds, and (iii) any other private grants, donations, gifts, or bequests designated for the Fund.

2009, cc. 26, 521.

§ 32.1-369. Uses of Breast and Cervical Cancer Prevention and Treatment Fund.

Moneys deposited to the Breast and Cervical Cancer Prevention and Treatment Fund shall be used to support the treatment of breast and cervical cancer for women under Medicaid pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, P.L. 106-354. Up to 10 percent of the Fund may be used annually to conduct screening activities for breast and cervical cancer under the Every Woman's Life Program administered by the Virginia Department of Health.

2009, cc. 26, 521.

Chapter 17 - BREASTFEEDING

§ 32.1-370. Right to breastfeed.

A mother may breastfeed in any place where the mother is lawfully present, including any location where she would otherwise be allowed on property that is owned, leased, or controlled by the Commonwealth in accordance with § 2.2-1147.1.

2015, cc. 45, 105.

Chapter 18 - RECOGNITION OF EMS PERSONNEL LICENSURE INTERSTATE COMPACT

§ 32.1-371. Recognition of Emergency Medical Services Personnel Licensure Interstate Compact.
The Recognition of Emergency Medical Services Personnel Licensure Interstate Compact is hereby enacted into law and entered into with all jurisdictions legally joining therein in the form substantially as follows:

SECTION 1. PURPOSE

In order to protect the public through verification of competency and ensure accountability for patient-care-related activities, all states license emergency medical services (EMS) personnel, such as emergency medical technicians (EMTs), advanced EMTs, and paramedics. This compact is intended to facilitate the day-to-day movement of EMS personnel across state boundaries in the performance of their EMS duties as assigned by an appropriate authority and authorize state EMS offices to afford immediate legal recognition to EMS personnel licensed in a member state. This compact recognizes that states have a vested interest in protecting the public's health and safety through their licensing and regulation of EMS personnel and that such state regulation shared among the member states will best protect public health and safety. This compact is designed to achieve the following purposes and objectives:

1. Increase public access to EMS personnel;

2. Enhance the states' ability to protect the public's health and safety, especially patient safety;

3. Encourage the cooperation of member states in the areas of EMS licensure and regulation;

4. Support licensing of military members who are separating from an active duty tour and licensing of their spouses;

5. Facilitate the exchange of information between member states regarding EMS personnel licensure, adverse action, and significant investigatory information;

6. Promote compliance with the laws governing EMS personnel practice in each member state; and

7. Invest all member states with the authority to hold EMS personnel accountable through the mutual recognition of member state licenses.

SECTION 2. DEFINITIONS

In this compact:

A. "Advanced Emergency Medical Technician (AEMT)" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

B. "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which may be imposed against licensed EMS personnel by a state EMS authority or state court,

including, but not limited to, actions against an individual's license such as revocation, suspension, probation, consent agreement, monitoring or other limitation or encumbrance on the individual's practice, letters of reprimand or admonition, fines, criminal convictions, and state court judgments enforcing adverse actions by the state EMS authority.

C. "Alternative program" means a voluntary, non-disciplinary substance abuse recovery program approved by a state EMS authority.

D. "Certification" means the successful verification of entry-level cognitive and psychomotor competency using a reliable, validated, and legally defensible examination.

E. "Commission" means the national administrative body of which all states that have enacted the compact are members.

F. "Emergency medical technician (EMT)" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

G. "Home state" means a member state where an individual is licensed to practice emergency medical services.

H. "License" means the authorization by a state for an individual to practice as an EMT, AEMT, or paramedic or at a level in between EMT and paramedic.

I. "Medical director" means a physician licensed in a member state who is accountable for the care delivered by EMS personnel.

J. "Member state" means a state that has enacted this compact.

K. "Privilege to practice" means an individual's authority to deliver emergency medical services in remote states as authorized under this compact.

L. "Paramedic" means an individual licensed with cognitive knowledge and a scope of practice that corresponds to that level in the National EMS Education Standards and National EMS Scope of Practice Model.

M. "Remote state" means a member state in which an individual is not licensed.

N. "Restricted" means the outcome of an adverse action that limits a license or the privilege to practice.

O. "Rule" means a written statement by the interstate Commission promulgated pursuant to Section 12 of this compact that is of general applicability; implements, interprets, or prescribes a policy or provision of the compact; or is an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a member state and includes the amendment, repeal, or suspension of an existing rule.

P. "Scope of practice" means defined parameters of various duties or services that may be provided by an individual with specific credentials. Whether regulated by rule, statute, or court decision, it tends to represent the limits of services an individual may perform.

Q. "Significant investigatory information" means:

1. Investigative information that a state EMS authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proved true, would result in the imposition of an adverse action on a license or privilege to practice; or

2. Investigative information that indicates that the individual represents an immediate threat to public health and safety regardless of whether the individual has been notified and had an opportunity to respond.

R. "State" means any state, commonwealth, district, or territory of the United States.

S. "State EMS authority" means the board, office, or other agency with the legislative mandate to license EMS personnel.

SECTION 3. HOME STATE LICENSURE

A. Any member state in which an individual holds a current license shall be deemed a home state for purposes of this compact.

B. Any member state may require an individual to obtain and retain a license to be authorized to practice in the member state under circumstances not authorized by the privilege to practice under the terms of this compact.

C. A home state's license authorizes an individual to practice in a remote state under the privilege to practice only if the home state:

1. Currently requires the use of the National Registry of Emergency Medical Technicians (NREMT) examination as a condition of issuing initial licenses at the EMT and paramedic levels;

2. Has a mechanism in place for receiving and investigating complaints about individuals;

3. Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding an individual;

4. No later than five years after activation of the compact, requires a criminal background check of all applicants for initial licensure, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation with the exception of federal employees who have suitability determination in accordance with 5 C.F.R. § 731.202 and submit documentation of such as promulgated in the rules of the Commission; and

5. Complies with the rules of the Commission.

SECTION 4. COMPACT PRIVILEGE TO PRACTICE

A. Member states shall recognize the privilege to practice of an individual licensed in another member state that is in conformance with Section 3.

B. To exercise the privilege to practice under the terms and provisions of this compact, an individual must:

1. Be at least 18 years of age;

2. Possess a current unrestricted license in a member state as an EMT, AEMT, paramedic, or state recognized and licensed level with a scope of practice and authority between EMT and paramedic; and

3. Practice under the supervision of a medical director.

C. An individual providing patient care in a remote state under the privilege to practice shall function within the scope of practice authorized by the home state unless and until modified by an appropriate authority in the remote state as may be defined in the rules of the Commission.

D. Except as provided in Section 4 subsection C, an individual practicing in a remote state will be subject to the remote state's authority and laws. A remote state may, in accordance with due process and that state's laws, restrict, suspend, or revoke an individual's privilege to practice in the remote state and may take any other necessary actions to protect the health and safety of its citizens. If a remote state takes action, it shall promptly notify the home state and the Commission.

E. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

F. If an individual's privilege to practice in any remote state is restricted, suspended, or revoked, the individual shall not be eligible to practice in any remote state until the individual's privilege to practice is restored.

SECTION 5. CONDITIONS OF PRACTICE IN A REMOTE STATE

An individual may practice in a remote state under a privilege to practice only in the performance of the individual's EMS duties as assigned by an appropriate authority, as defined in the rules of the Commission, and under the following circumstances:

1. The individual originates a patient transport in a home state and transports the patient to a remote state;

2. The individual originates in the home state and enters a remote state to pick up a patient and provide care and transport of the patient to the home state;

3. The individual enters a remote state to provide patient care and/or transport within that remote state;

4. The individual enters a remote state to pick up a patient and provide care and transport to a third member state;

5. Other conditions as determined by rules promulgated by the Commission.

SECTION 6. RELATIONSHIP TO EMERGENCY MANAGEMENT ASSISTANCE COMPACT

Upon a member state's governor's declaration of a state of emergency or disaster that activates the Emergency Management Assistance Compact (EMAC), all relevant terms and provisions of EMAC shall apply and to the extent any terms or provisions of this compact conflict with EMAC, the terms of EMAC shall prevail with respect to any individual practicing in the remote state in response to such declaration.

SECTION 7. VETERANS, SERVICE MEMBERS SEPARATING FROM ACTIVE DUTY MILITARY, AND THEIR SPOUSES

A. Member states shall consider a veteran, active military service member, and member of the National Guard and Reserves separating from an active duty tour, and a spouse thereof, who holds a current valid and unrestricted NREMT certification at or above the level of the state license being sought as satisfying the minimum training and examination requirements for such licensure.

B. Member states shall expedite the processing of licensure applications submitted by veterans, active military service members, and members of the National Guard and Reserves separating from an active duty tour, and their spouses.

C. All individuals functioning with a privilege to practice under this Section remain subject to the adverse actions provisions of Section 8.

SECTION 8. ADVERSE ACTIONS

A. A home state shall have exclusive power to impose adverse action against an individual's license issued by the home state.

B. If an individual's license in any home state is restricted or suspended, the individual shall not be eligible to practice in a remote state under the privilege to practice until the individual's home state license is restored.

1. All home state adverse action orders shall include a statement that the individual's compact privileges are inactive. The order may allow the individual to practice in remote states with prior written authorization from both the home state and remote state's EMS authority.

2. An individual currently subject to adverse action in the home state shall not practice in any remote state without prior written authorization from both the home state and remote state's EMS authority.

C. A member state shall report adverse actions and any occurrences that the individual's compact privileges are restricted, suspended, or revoked to the Commission in accordance with the rules of the Commission.

D. A remote state may take adverse action on an individual's privilege to practice within that state.

E. Any member state may take adverse action against an individual's privilege to practice in that state based on the factual findings of another member state, so long as each state follows its own procedures for imposing such adverse action.

F. A home state's EMS authority shall investigate and take appropriate action with respect to reported conduct in a remote state as it would if such conduct had occurred within the home state. In such cases, the home state's law shall control in determining the appropriate adverse action.

G. Nothing in this compact shall override a member state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the member state's laws. Member states must require individuals who enter any alternative programs to agree not to practice in any other member state during the term of the alternative program without prior authorization from such other member state.

SECTION 9. ADDITIONAL POWERS INVESTED IN A MEMBER STATE'S EMS AUTHORITY

A member state's EMS authority, in addition to any other powers granted under state law, is authorized under this compact to:

1. Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a member state's EMS authority for the attendance and testimony of witnesses, and/or the production of evidence from another member state, shall be enforced in the remote state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing state's EMS authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located; and

2. Issue cease and desist orders to restrict, suspend, or revoke an individual's privilege to practice in the state.

SECTION 10. ESTABLISHMENT OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE

A. The compact states hereby create and establish a joint public agency known as the Interstate Commission for EMS Personnel Practice.

1. The Commission is a body politic and an instrumentality of the compact states.

2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

3. Nothing in this compact shall be construed to be a waiver of sovereign immunity.

B. Membership, Voting, and Meetings.

1. Each member state shall have and be limited to one (1) delegate. The responsible official of the state EMS authority or his designee shall be the delegate to this compact for each member state. Any delegate may be removed or suspended from office as provided by the law of the state from which the delegate is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the member state in which the vacancy exists. In the event that more than one board, office, or other agency with the legislative mandate to license EMS personnel at and above the level of EMT exists, the governor of the state will determine which entity will be responsible for assigning the delegate.

2. Each delegate shall be entitled to one (1) vote with regard to the promulgation of rules and creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A delegate shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for delegates' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

4. All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rulemaking provisions in Section 12.

5. The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a member state with its obligations under the compact;

b. The employment, compensation, discipline or other personnel matters, practices or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusing any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law-enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to the compact; or

j. Matters specifically exempted from disclosure by federal or member state statute.

6. If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the Commission or order of a court of competent jurisdiction.

C. The Commission shall, by a majority vote of the delegates, prescribe bylaws and/or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the compact, including but not limited to:

1. Establishing the fiscal year of the Commission;

2. Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

3. Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the membership votes to close a meeting in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed;

4. Establishing the titles, duties and authority, and reasonable procedures for the election of the officers of the Commission;

5. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any member state, the bylaws shall exclusively govern the personnel policies and programs of the Commission;

6. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees;

7. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and/or reserving of all of its debts and obligations;

8. Publishing its bylaws and filing a copy thereof, and a copy of any amendment thereto, with the appropriate agency or officer in each of the member states, if any;

9. Maintaining its financial records in accordance with the bylaws; and

10. Meeting and taking such actions as are consistent with the provisions of this compact and the bylaws.

D. The Commission shall have the following powers:

1. To promulgate uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and shall be binding in all member states;

2. To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any state EMS authority or other regulatory body responsible for EMS personnel licensure to sue or be sued under applicable law shall not be affected;

3. To purchase and maintain insurance and bonds;

4. To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a member state;

5. To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the compact, and to establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

6. To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

7. To lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

8. To sell convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

9. To establish a budget and make expenditures;

10. To borrow money;

11. To appoint committees, including advisory committees composed of members, state regulators, state legislators or their representatives, and consumer representatives and such other interested persons as may be designated in this compact and the bylaws;

12. To provide and receive information from, and cooperate with, law-enforcement agencies;

13. To adopt and use an official seal; and

14. To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of EMS personnel licensure and practice.

E. Financing of the Commission.

1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

2. The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

3. The Commission may levy on and collect an annual assessment from each member state or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission, which shall promulgate a rule binding upon all member states.

4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the Commission pledge the credit of any of the member states, except by and with the authority of the member state.

5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Commission.

F. Qualified Immunity, Defense, and Indemnification.

1. The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of Commission employment, duties, or responsibilities, provided that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

2. The Commission shall defend any member, officer, executive director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

3. The Commission shall indemnify and hold harmless any member, officer, executive director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

SECTION 11. COORDINATED DATABASE

A. The Commission shall provide for the development and maintenance of a coordinated database and reporting system containing licensure, adverse action, and significant investigatory information on all licensed individuals in member states.

B. Notwithstanding any other provision of state law to the contrary, a member state shall submit a uniform data set to the coordinated database on all individuals to whom this compact is applicable as required by the rules of the Commission, including:

1. Identifying information;

2. Licensure data;

3. Significant investigatory information;

4. Adverse actions against an individual's license;

5. An indicator that an individual's privilege to practice is restricted, suspended, or revoked;

6. Nonconfidential information related to alternative program participation;

7. Any denial of application for licensure and the reason(s) for such denial; and

8. Other information that may facilitate the administration of this compact, as determined by the rules of the Commission.

C. The coordinated database administrator shall promptly notify all member states of any adverse action taken against, or significant investigative information on, any individual in a member state.

D. Member states contributing information to the coordinated database may designate information that may not be shared with the public without the express permission of the contributing state.

E. Any information submitted to the coordinated database that is subsequently required to be expunged by the laws of the member state contributing the information shall be removed from the coordinated database.

SECTION 12. RULEMAKING

A. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this Section and the rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

B. If a majority of the legislatures of the member states rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the compact, then such rule shall have no further force and effect in any member state.

C. Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

D. Prior to promulgation and adoption of a final rule or rules by the Commission, and at least sixty (60) days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rulemaking:

1. On the website of the Commission; and

2. On the website of each member state EMS authority or the publication in which each state would otherwise publish proposed rules.

E. The Notice of Proposed Rulemaking shall include:

1. The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

2. The text of the proposed rule or amendment and the reason for the proposed rule;

3. A request for comments on the proposed rule from any interested person; and

4. The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

F. Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

G. The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

1. At least twenty-five (25) persons;

2. A governmental subdivision or agency; or

3. An association having at least twenty-five (25) members.

H. If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

1. All persons wishing to be heard at the hearing shall notify the executive director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five (5) business days before the scheduled date of the hearing.

2. Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

3. No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

4. Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

I. Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

J. The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

K. If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in the compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than ninety (90) days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

1. Meet an imminent threat to public health, safety, or welfare;

2. Prevent a loss of Commission or member state funds;

3. Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

4. Protect public health and safety.

M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of thirty (30) days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

SECTION 13. OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

A. Oversight.

1. The executive, legislative, and judicial branches of state government in each member state shall enforce this compact and take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this compact which may affect the powers, responsibilities, or actions of the Commission.

3. The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this compact, or promulgated rules.

B. Default, Technical Assistance, and Termination.

1. If the Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other member states of the nature of the default, the proposed means of curing the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

2. If a state in default fails to cure the default, the defaulting state may be terminated from the compact upon an affirmative vote of a majority of the member states, and all rights, privileges, and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

3. Termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

4. A state that has been terminated from the compact is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

5. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from the compact, unless agreed upon in writing between the Commission and the defaulting state.

6. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

C. Dispute Resolution.

1. Upon request by a member state, the Commission shall attempt to resolve disputes related to the compact that arise among member states and between member and nonmember states.

2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.

D. Enforcement.

1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. By majority vote, the Commission may initiate legal action in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices against a member state in default to enforce compliance with the provisions of the compact and its promulgated rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorney fees.

3. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

SECTION 14. DATE OF IMPLEMENTATION OF THE INTERSTATE COMMISSION FOR EMS PERSONNEL PRACTICE AND ASSOCIATED RULES, WITHDRAWAL, AND AMENDMENT

A. The compact shall come into effect on the date on which the compact statute is enacted into law in the tenth member state. The provisions, which become effective at that time, shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rulemaking powers necessary to the implementation and administration of the compact.

B. Any state that joins the compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the compact becomes law in that state.

C. Any member state may withdraw from this compact by enacting a statute repealing the same.

1. A member state's withdrawal shall not take effect until six (6) months after enactment of the repealing statute.

2. Withdrawal shall not affect the continuing requirement of the withdrawing state's EMS authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

D. Nothing contained in this compact shall be construed to invalidate or prevent any EMS personnel licensure agreement or other cooperative arrangement between a member state and a nonmember state that does not conflict with the provisions of this compact.

E. This compact may be amended by the member states. No amendment to this compact shall become effective and binding upon any member state until it is enacted into the laws of all member states.

SECTION 15. CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. If this compact shall be held contrary to the constitution of any member state thereto, the compact shall remain in full force and effect as to the remaining member states. Nothing in this compact supersedes state law or rules related to licensure of EMS agencies.

2016, cc. 75, 107.

Chapter 19 - Smartchart Network Program

§ 32.1-372. (Effective until January 1, 2024) Emergency Department Care Coordination Program established; purpose.

A. The Emergency Department Care Coordination Program (the Program) is hereby created to provide a single, statewide technology solution that connects all hospital emergency departments in the Commonwealth to facilitate real-time communication and collaboration among physicians, other health care providers, and clinical and care management personnel for patients receiving services in hospital emergency departments, for the purpose of improving the quality of patient care services.

B. In developing and implementing the Program, the Commissioner shall ensure that the Program:

1. Receives real-time patient visit information from, and shares such information with, every hospital emergency department in the Commonwealth through integrations that enable receiving information from and delivering information into electronic health records systems utilized by such hospital emergency departments;

2. Requires that all participants in the Program have fully executed health care data exchange contracts that ensure that the secure and reliable exchange of patient information fully complies with patient privacy and security requirements of applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.);

3. Allows hospital emergency departments in the Commonwealth to receive real-time alerts triggered by analytics to identify patient-specific risks, to create and share care coordination plans and other care recommendations, and to access other clinically beneficial information related to patients receiving services in hospital emergency departments in the Commonwealth;

4. Provides a patient's designated primary care physician and supporting clinical and care management personnel with treatment and care coordination information about a patient receiving

services in a hospital emergency department in the Commonwealth, including care plans and hospital admissions, transfers, and discharges;

5. Provides a patient's designated managed care organization and supporting clinical and care management personnel with care coordination plans and discharge and other treatment and care coordination information about a member receiving services in a hospital emergency department in the Commonwealth; and

6. Is integrated with the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and the Advance Health Care Directive Registry established pursuant to Article 9 (§ 54.1-2994 et seq.) of Chapter 29 of Title 54.1 to enable automated query and automatic delivery of relevant information from such sources into the existing work flow of health care providers in the emergency department.

C. The Commissioner shall enter into a contract with a third party to create, operate, maintain, or administer the Program in accordance with this section, which shall include provisions for the protection of patient privacy and data security pursuant to state and federal law and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.). The third-party contractor shall establish an advisory council, which shall consist of representatives of the Department, the Department of Medical Assistance Services, the Department of Health Professions, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatricians, and the Virginia Academy of Family Physicians, to advise the Commissioner and the third-party contractor regarding the establishment and operation of the Program, changes to the Program, and outcome measures for the Program.

D. Information submitted to the Program shall be confidential and shall be exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

2017, cc. 475, 600.

§ 32.1-372. (Effective January 1, 2024) Smartchart Network Program established; purpose.

A. The Smartchart Network Program (the Program) is hereby created to provide a single, statewide technology solution that connects all health care providers, insurance carriers, and other organizations with a treatment, payment, or operations relationship with a patient in the Commonwealth to facilitate real-time communication and collaboration and improve the quality of patient care services.

B. The Commissioner shall ensure that the Program:

1. Receives real-time patient visit information from, and shares such information with, every hospital in the Commonwealth through integrations that enable receiving information from and delivering information into electronic health records systems utilized by such hospitals;

2. Requires that all participants in the Program share patient information and have fully executed health care data exchange contracts to ensure the secure and reliable exchange of patient information

in compliance with the patient privacy and security requirements of applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.);

3. Enables health care providers, health care entities, and insurance carriers to access information necessary to evaluate and monitor the care and treatment of a patient in accordance with the patient privacy and security requirements of applicable state and federal laws and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.);

4. Allows health care providers in the Commonwealth to receive real-time alerts triggered by analytics to identify patient-specific risks, to create and share care coordination plans and other care recommendations, and to access other clinically beneficial information related to patients receiving health care services in the Commonwealth, including strategies and methods to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers;

5. Provides a patient's designated primary care physician and supporting clinical and care management personnel with treatment and care coordination information about a patient receiving health care services in the Commonwealth, including care plans, lab results, images, and hospital admissions, transfers, and discharges;

6. Provides a patient's designated managed care organization and supporting clinical and care management personnel with care coordination plans, lab results, images, and discharge and other treatment and care coordination information about a member receiving health care services in the Commonwealth; and

7. Is integrated with the Prescription Monitoring Program established pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and the Advance Health Care Directive Registry established pursuant to Article 9 (§ 54.1-2994 et seq.) of Chapter 29 of Title 54.1 to enable automated query and automatic delivery of relevant information from such sources into the existing work flow of health care providers.

C. The Commissioner shall enter into a contract with a third party to create, operate, maintain, or administer the Program in accordance with this section, which shall include provisions for the protection of patient privacy and data security pursuant to state and federal law and regulations, including the Health Insurance Portability and Accountability Act (42 U.S.C. § 1320d et seq.). The third-party contractor shall continue and rename the Emergency Department Care Coordination Advisory Council established by Chapter 836 of the Acts of Assembly of 2017 as the Smartchart Network Program Advisory Council (the Advisory Council), which shall consist of representatives of the Department, the Department of Medical Assistance Services, the Department of Health Professions, the Virginia Hospital and Healthcare Association, the Virginia Association of Health Plans, the Medical Society of Virginia, the Virginia College of Emergency Physicians, the Virginia Chapter of the American Academy of Pediatricians, and the Virginia Academy of Family Physicians, to advise the Commissioner and the

third-party contractor regarding the establishment and operation of the Program, changes to the Program, and outcome measures for the Program.

The Advisory Council established pursuant to this subsection shall continue to ensure that information is shared among emergency departments throughout the Commonwealth and all hospitals operating emergency departments in the Commonwealth, all Medicaid managed care contracted health plans, the state employee health insurance plan, all Medicare plans operating in the Commonwealth, and all commercial plans operating in the Commonwealth, excluding ERISA plans, and shall participate in the emergency department information exchange program to continue to improve care coordination in hospital emergency departments and reduce the frequency of visits by high-volume emergency department utilizers.

D. Information submitted to the Program shall be confidential and shall be exempt from disclosure under the Virginia Freedom of Information Act (§ 2.2-3700 et seq.).

2017, cc. 475, 600; 2023, cc. 628, 629.

Chapter 20 - Disposition of Assets by Nonprofit Health Care Entities

§ 32.1-373. Definitions.

As used in this chapter, unless the context requires a different meaning:

"Disposition of assets" means any action undertaken by a nonprofit entity to dispose of control of all or substantially all of its assets pursuant to an agreement of sale, transfer, lease, exchange, option, joint venture, or partnership, or to convert to a for-profit entity or to otherwise restructure the nonprofit entity or its assets, resulting in a change in control or governance of the entity or assets.

"Nonprofit entity" means (i) a foreign or domestic nonstock corporation licensed and subject to regulation under Chapter 42 (§ 38.2-4200 et seq.) of Title 38.2 or (ii) a person that is exempt from taxation under 26 U.S.C. § 501(c)(3) or (4) and is, or owns, one of the following: (a) a hospital licensed under Chapter 5 (§ 32.1-123 et seq.) of this title or Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2; (b) a health maintenance organization licensed under Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2; (c) a nursing home, including a facility known by varying nomenclature or designation such as convalescent home, skilled nursing facility or skilled care facility, intermediate care facility, extended care facility, or certified nursing facility or nursing care facility, licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of Chapter 5; or (d) a facility for the provision of continuing care registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2.

1997, c. 615, § 55-531; 2000, c. 266; 2002, c. 516; 2005, c. 839; 2019, c. 712.

§ 32.1-374. Obligations of nonprofit entity.

Prior to disposition of assets, any nonprofit entity shall provide to the Attorney General written notice, on a form provided by the Attorney General, of its intent to dispose of such assets, including the terms of the proposal. The notice shall be given at least 60 days in advance of the effective date of such proposed transaction in order that the Attorney General may exercise his common law and statutory

authority over the activities of these organizations. The Attorney General may employ expert assistance in reviewing any proposed transaction, and such reasonable expenses incurred by the Attorney General shall be paid by a party to the proposed transaction.

Within 10 days of receipt of the notice from the entity, the Attorney General shall cause a public notice of the transaction to be published in a newspaper in which legal notices may be published in that jurisdiction.

No later than 40 days prior to any disposition of assets, the nonprofit entity shall convene a public meeting to set forth its expectations concerning how the health care needs of the community will be served following the proposed disposition of assets and to receive comments and respond to questions on the potential impact of the proposed disposition of assets on the community served by the nonprofit entity. Notice of the time and place of such meeting shall be published at least 10 days prior to the meeting in a newspaper in which legal notices may be published in that jurisdiction.

Notice to the Attorney General pursuant to this section shall be given for State Corporation Commission approval sought pursuant to Article 11 (§ 13.1-893.1) of Chapter 10 of Title 13.1 and §§ 38.2-203 and 38.2-1322 through 38.2-1328 and subdivision A 1 of § 38.2-4316. Such notice need not be given where the State Corporation Commission determines, in its sole discretion, that there is a reasonable expectation that the foreign or domestic nonstock corporation licensed and subject to regulation under Chapter 42 (§ 38.2-4200 et seq.) of Title 38.2 or health maintenance organization referenced in this chapter will not be able to meet its obligations to subscribers or enrollees.

The provisions of this section shall not apply to any disposition of assets subject to the provisions of § 38.2-4214.1 or any of the provisions of Chapter 15 (§ 38.2-1500 et seq.) of Title 38.2.

1997, c. 615, § 55-532; 2002, c. 516; 2007, c. 925; 2008, c. 253; 2018, c. 706; 2019, c. 712.

§ 32.1-375. Applicability of chapter.

This chapter shall apply to any disposition of assets proposed to take effect on or after July 1, 1997.

1997, c. 615, § 55-533; 2019, c. 712.