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SENATE BILL NO. 910

Offered January 8, 2025

Prefiled January 5, 2025

A BILL to amend and reenact §§ 2.2-4006, 15.2-5386, 23.1-2412, 32.1-3, 32.1-23.5, 32.1-102.1:1, 32.1-102.1:3, 32.1-122.05, 32.1-122.10:001, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-162.1, 32.1-276.5, 54.1-2400.6, *and* 54.1-2937.1 *of the Code of Virginia and to repeal Article 1.1 (§§* 32.1-102.1 *through* 32.1-102.11*) of Chapter 4 of Title 32.1 of the Code of Virginia, relating to certificate of public need program; phased elimination.*

Patron—Stanley

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-3 and 32.1-102.1:3 of the Code of Virginia are amended and reenacted as follows:

§ 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~~ *2* 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.

§ 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.~~ *2.* 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 residents 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.

2. That §§ 32.1-3, 32.1-102.1:1, and 32.1-102.1:3 of the Code of Virginia are amended and reenacted as follows:

§ 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~~ *2* 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.

§ 32.1-102.1:1. Equipment registration required.

~~Within thirty calendar days of becoming~~ *Any person who becomes* 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~~ *for the purpose of providing such services at any existing medical care facility located outside of a metropolitan statistical area or in a rural census tract within a metropolitan statistical area* shall register such purchase with the Commissioner and the appropriate regional health planning agency *within 30 days of becoming so obligated*.

§ 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~~

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~~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.~~ *2.* 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 *that are located outside of a metropolitan statistical area or in a rural census tract within a metropolitan area.*

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 residents 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.

3. That §§ 2.2-4006, 15.2-5386, 23.1-2412, 32.1-3, 32.1-23.5, 32.1-122.05, 32.1-122.10:001, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-162.1, 32.1-276.5, 54.1-2400.6, and 54.1-2937.1 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-4006. Exemptions from requirements of this article.

A. The following agency actions otherwise subject to this chapter and § 2.2-4103 of the Virginia Register Act shall be exempted from the operation of this article:

1. Agency orders or regulations fixing rates or prices.

2. Regulations that establish or prescribe agency organization, internal practice or procedures, including delegations of authority.

3. Regulations that consist only of changes in style or form or corrections of technical errors. Each promulgating agency shall review all references to sections of the Code of Virginia within their regulations each time a new supplement or replacement volume to the Code of Virginia is published to ensure the accuracy of each section or section subdivision identification listed.

4. Regulations that are:

a. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved. However, such regulations shall be filed with the Registrar within 90 days of the law's effective date;

b. Required by order of any state or federal court of competent jurisdiction where no agency discretion is involved; or

c. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing. Notice of the proposed adoption of these regulations and the Registrar's determination shall be published in the Virginia Register not less than 30 days prior to the effective date of the regulation.

5. Regulations of the Board of Agriculture and Consumer Services adopted pursuant to subsection B of § 3.2-3929 or clause (v) or (vi) of subsection C of § 3.2-3931 after having been considered at two or more Board meetings and one public hearing.

6. Regulations of (i) the regulatory boards served by the Department of Labor and Industry pursuant to Title 40.1 and the Department of Professional and Occupational Regulation or the Department of Health Professions pursuant to Title 54.1 and (ii) the Board of Accountancy that are limited to reducing fees charged to regulants and applicants.

7. The development and issuance of procedural policy relating to risk-based mine inspections by the Department of Energy authorized pursuant to §§ 45.2-560 and 45.2-1149.

8. General permits issued by ~~the~~ ~~(a)~~ *(i) the* State Air Pollution Control Board pursuant to Chapter 13 (§

10.1-1300 et seq.) of Title 10.1 ~~or (b)~~, *(ii) the* State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), Chapter 24 (§ 62.1-242 et seq.) of Title 62.1, and Chapter 25 (§ 62.1-254 et seq.) of Title 62.1, ~~(c)~~ *(iii) the* Virginia Soil and Water Conservation Board pursuant to the Dam Safety Act (§ 10.1-604 et seq.), and ~~(d)~~ *(iv)* the development and issuance of general wetlands permits by the Marine Resources Commission pursuant to subsection B of § 28.2-1307, if the respective Board or Commission ~~(i)~~ *(a)* provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, ~~(ii)~~ *(b)* following the passage of 30 days from the publication of the Notice of Intended Regulatory Action forms a technical advisory committee composed of relevant stakeholders, including potentially affected citizens groups, to assist in the development of the general permit, ~~(iii)~~ *(c)* provides notice and receives oral and written comment as provided in § 2.2-4007.03, and ~~(iv)~~ *(d)* conducts at least one public hearing on the proposed general permit.

9. The development and issuance by the Board of Education of guidelines on constitutional rights and restrictions relating to the recitation of the pledge of allegiance to the American flag in public schools pursuant to § 22.1-202.

10. Regulations of the Board of the Commonwealth Savers Plan adopted pursuant to § 23.1-704.

11. Regulations of the Marine Resources Commission.

12. Regulations adopted by the Board of Housing and Community Development pursuant to (i) Statewide Fire Prevention Code (§ 27-94 et seq.), (ii) the Industrialized Building Safety Law (§ 36-70 et seq.), (iii) the Uniform Statewide Building Code (§ 36-97 et seq.), and (iv) § 36-98.3, provided the Board (a) provides a Notice of Intended Regulatory Action in conformance with the provisions of § 2.2-4007.01, (b) publishes the proposed regulation and provides an opportunity for oral and written comments as provided in § 2.2-4007.03, and (c) conducts at least one public hearing as provided in §§ 2.2-4009 and 36-100 prior to the publishing of the proposed regulations. Notwithstanding the provisions of this subdivision, any regulations promulgated by the Board shall remain subject to the provisions of § 2.2-4007.06 concerning public petitions, and §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

13. Amendments to regulations of the Board to schedule a substance pursuant to subsection D or E of § 54.1-3443.

14. Waste load allocations adopted, amended, or repealed by the State Water Control Board pursuant to the State Water Control Law (§ 62.1-44.2 et seq.), including but not limited to Article 4.01 (§ 62.1-44.19:4 et seq.) of the State Water Control Law, if the Board (i) provides public notice in the Virginia Register; (ii) if requested by the public during the initial public notice 30-day comment period, forms an advisory group composed of relevant stakeholders; (iii) receives and provides summary response to written comments; and (iv) conducts at least one public meeting. Notwithstanding the provisions of this subdivision, any such waste load allocations adopted, amended, or repealed by the Board shall be subject to the provisions of §§ 2.2-4013 and 2.2-4014 concerning review by the Governor and General Assembly.

15. Regulations of the Workers' Compensation Commission adopted pursuant to § 65.2-605, including regulations that adopt, amend, adjust, or repeal Virginia fee schedules for medical services, provided the Workers' Compensation Commission (i) utilizes a regulatory advisory panel constituted as provided in subdivision F 2 of § 65.2-605 to assist in the development of such regulations and (ii) provides an opportunity for public comment on the regulations prior to adoption.

16. Amendments to the State Health Services Plan adopted by the Board of Health following receipt of recommendations by the State Health Services Task Force ~~pursuant to § 32.1-102.2:1~~ if the Board (i) provides a Notice of Intended Regulatory Action in accordance with the requirements of § 2.2-4007.01, (ii) provides notice and receives comments as provided in § 2.2-4007.03, and (iii) conducts at least one public hearing on the proposed amendments.

17. Rules of the Workers' Compensation Commission adopted pursuant to subsection A of § 65.2-201 and subsection B of § 65.2-703, provided the Workers' Compensation Commission provides an opportunity for public comment on the rules prior to adoption.

B. Whenever regulations are adopted under this section, the agency shall state as part thereof that it will receive, consider and respond to petitions by any interested person at any time with respect to reconsideration or revision. The effective date of regulations adopted under this section shall be in accordance with the provisions of § 2.2-4015, except in the case of emergency regulations, which shall become effective as provided in subsection B of § 2.2-4012.

C. A regulation for which an exemption is claimed under this section or § 2.2-4002 or 2.2-4011 and that is placed before a board or commission for consideration shall be provided at least two days in advance of the board or commission meeting to members of the public that request a copy of that regulation. A copy of that regulation shall be made available to the public attending such meeting.

§ 15.2-5386. Limitations of the Authority.

A. No provision related to the establishment, powers, or authorities of the Southwest Virginia Health Authority, *or* its subsidiaries~~,~~ or successors, shall apply to the facilities, equipment, or appropriations of any state agency, including~~, but not limited to,~~ the Virginia Department of Health and the Department of

Behavioral Health and Developmental Services.

B. ~~The Authority, its subsidiaries or successors, shall not be exempt from the Certificate of Public Need law and regulations or licensure standards of the Virginia Department of Health.~~

~~C.~~ No provision of this chapter related to the establishment, power, or authority of the Authority or participating localities shall apply to or affect any hospital as defined in § 32.1-123.

§ 23.1-2412. Transfer of existing hospital facilities.

A. The University may lease, convey, or otherwise transfer to the Authority any or all assets and liabilities appearing on the balance sheet of MCV Hospitals and any or all of the hospital facilities, except real estate that may be leased to the Authority for a term not to exceed 99 years, upon such terms as may be approved by the University.

B. Any transfer of hospital facilities pursuant to subsection A is conditioned upon the existence of a binding agreement between the University and the Authority:

1. That requires the Authority to assume, directly or indirectly, hospital obligations that are directly relating to the hospital facilities or any part of the hospital facilities that are transferred, including rentals as provided in subsection C or a combination of rentals and other obligations in the case of a lease of hospital facilities;

2. That provides that, effective on the transfer date, the Authority shall assume responsibility for, defend, indemnify, and hold harmless the University and its officers and directors with respect to:

a. All liabilities and duties of the University pursuant to contracts, agreements, and leases for commodities, services, and supplies used by MCV Hospitals, including property leases;

b. All claims relating to the employment relationship between employees of the Authority and the University on and after the transfer date;

c. All claims for breach of contract resulting from the Authority's action or failure to act on and after the transfer date;

d. All claims relating to the Authority's errors and omissions, including medical malpractice, directors' and officers' liability, workers' compensation, automobile liability, premises liability, completed operations liability, and products liability resulting from the Authority's action or failure to act on and after the transfer date; and

3. By which the Authority shall accept and agree to abide by provisions that ensure the continued support of the education, research, patient care, and public service missions of MCV Hospitals, including:

a. A requirement that the Authority continue to provide emergency and inpatient indigent care services on the MCV campus of the University in locations including downtown Richmond; and

b. A requirement that the Authority continue to act as the primary teaching facility for the Virginia Commonwealth University School of Medicine and the Health Sciences Schools of the University.

C. Any lease of hospital facilities from the University to the Authority may include a provision that requires the Authority to pay the University a rental payment for the hospital facilities that are leased. For those hospital facilities for which rent is paid, the rent shall be at least equal to the greater of:

1. The debt service accruing during the term of the lease on all outstanding bonds issued for the purpose of financing the acquisition, construction, or improvement of the hospital facilities on which rent is paid; or

2. A nominal amount determined by the parties to be necessary to prevent the lease from being unenforceable because of a lack of consideration.

D. Any lease of hospital facilities shall include a provision that requires the Authority to continue to support the education, research, patient care, and public service missions of MCV Hospitals, including:

1. A requirement that the Authority continue to provide emergency and inpatient indigent care services on the MCV campus of the University in locations including downtown Richmond; and

2. A requirement that the Authority continue to act as the primary teaching facility for the Health Sciences Schools of the University.

E. All other agencies and officers of the Commonwealth shall take such actions as may be necessary or desirable in the judgment of the University to permit such conveyance and the full use and enjoyment of the hospital facilities, including the transfer of property of any type held in the name of the Commonwealth or an instrumentality or agency of the Commonwealth but used by the University in the operation of the hospital facilities.

F. The Authority may pay to or on behalf of the University some or all of the costs of the hospital facilities. The University may apply some or all of such proceeds to the payment or defeasance of its obligations issued to finance the hospital facilities, and the Authority may issue its bonds to finance or refinance such payment.

G. Funds held by or for the University or any of its predecessors or divisions, including funds held by the University Foundation or the MCV Foundation for the benefit of MCV Hospitals or any of its predecessors for use in operating, maintaining, or constructing hospital facilities, providing medical and health sciences education, or conducting medical or related research may be transferred, in whole or in part, to the Authority if the University or any foundation determines that the transfer is consistent with the intended use of the

funds. The University may direct in writing that all or part of the money or property representing its beneficial interest under a will, trust agreement, or other donative instrument be distributed to the Authority if the University determines that such direction furthers any of the original purposes of the will, trust agreement, or other instrument. Such a direction shall not be considered a waiver, disclaimer, renunciation, assignment, or disposition of the beneficial interest by the University. A fiduciary's distribution to the Authority pursuant to such a written direction from the University is a distribution to the University for all purposes relating to the donative instrument, and the fiduciary has no liability for distributing any money or property to the Authority pursuant to such a direction. Nothing in this section shall deprive any court of its jurisdiction to determine whether such a distribution is appropriate under its cy pres powers or otherwise.

H. The Authority shall not operate any hospital pursuant to this section prior to execution of the lease and agreement required by this section and such other agreements as may be necessary or convenient in the University's judgment to provide for the transfer of the operations of the hospital facilities to the Authority, unless and to the extent that the University approves otherwise.

I. The University may assign and the Authority may accept the rights and assume the obligations under any contract or other agreement of any type relating to financing or operating the hospital facilities. Upon evidence that such assignment and acceptance has been made, all agencies and instrumentalities of the Commonwealth shall consent to such assignment and accept the substitution of the Authority for the University as a party to such agreement to the extent that the University's obligations under such agreement relate to the ownership, operation, or financing of the hospital facilities. Indebtedness previously incurred by the Commonwealth, the Virginia Public Building Authority, the Virginia College Building Authority, and any other agency or instrumentality of the Commonwealth to finance the hospital facilities may continue to remain outstanding after the transfer and assignment of such agreement by the University to the Authority.

J. ~~The transfer of the hospital facilities from the University to the Authority does not require a certificate of public need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1.~~ All licenses, permits~~, certificates of public need~~, or other authorizations of the Commonwealth, any agency of the Commonwealth, or any locality held by the University in connection with the ownership or operation of the hospital facilities are transferred without further action to the Authority to the extent that the Authority undertakes the activity permitted by such authorizations. All agencies and officers of the Commonwealth and all localities shall confirm such transfer by the issuance of new or amended licenses, permits~~, certificates of public need~~, or other authorizations upon the request of the University and the Authority.

K. If for any reason the Authority cannot replace the University as a party to any agreement in connection with the financing, ownership, or operation of the hospital facilities, the Authority and the University may require the Authority to act as agent for the University in carrying out its obligations under such agreement or receiving the benefits under such agreement, or both.

§ 32.1-3. Definitions.

As used in this title unless the context requires ~~otherwise or it is otherwise provided~~ *a different meaning*:

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

"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 of 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.

"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.

§ 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 and Human Services and the Senate Committees on Finance and Appropriations and Education and Health regarding data collected pursuant to subsection ~~F~~ *E* 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~~ *E* 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.

§ 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~~ *30* 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; *and* (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.

§ 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~~ *that* 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.

§ 32.1-125.3. 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).

§ 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~~ *12* 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.~~

§ 32.1-126.3. Fire suppression systems required in hospitals.

A. 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.~~

B. 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.

§ 32.1-162.1. Definitions.

As used in this article, unless *the context requires* 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~~ *that* are experienced during the final stages of illness, and during dying and bereavement. Hospice care shall be available ~~twenty-four~~ *24* 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~~ *means* 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.

§ 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.~~ *D.* 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.~~ *E.* 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.~~ *F.* The Board shall evaluate biennially the impact and effectiveness of such data collection.

§ 54.1-2400.6. Hospitals, other health care institutions, home health and hospice organizations, and assisted living facilities required to report disciplinary actions against and certain disorders of health professionals; immunity from liability; failure to report.

A. The chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth, the director of every licensed home health or hospice organization, the director of every accredited home health organization exempt from licensure, the administrator of every licensed assisted living facility, and the administrator of every provider licensed by the Department of Behavioral Health and Developmental Services in the Commonwealth shall report within 30 days, except as provided in subdivisions 1 and 2, to the Director of the Department of Health Professions, or in the case of a director of a home health or hospice organization, to the Office of Licensure and Certification at the Department of Health (the Office), the following information regarding any person (i) licensed, certified, or registered by a health regulatory board or (ii) holding a multistate licensure privilege to practice nursing or an applicant for licensure, certification or registration unless exempted under subsection E:

1. Any information of which he may become aware in his official capacity indicating a reasonable belief that such a health professional has been involuntarily admitted as a patient, either in his own institution or any

other health care institution, for treatment of substance abuse or a psychiatric illness. The report required by this subdivision shall be made within five days of the date on which the chief executive officer, chief of staff, director, or administrator learns of the health care professional's involuntary admission.

2. Any information of which he may become aware in his official capacity indicating a reasonable belief that such a health professional has been voluntarily admitted as a patient, either at his institution or any other health care institution, for treatment of a substance abuse or psychiatric illness and such substance abuse or psychiatric illness may continue for more than 30 days after admission. A report required by this subdivision shall be made within five days after the 30-day period concludes unless the physician, physician assistant, or nurse practitioner treating the health professional for substance abuse or psychiatric illness provides written confirmation to the entity required to make such report that the health professional no longer is believed to be a danger to himself, the public, or his patients.

3. Any information of which he may become aware in his official capacity indicating a reasonable belief, after review and, if necessary, an investigation or consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, that a health professional may have engaged in unethical, fraudulent or unprofessional conduct as defined by the pertinent licensing statutes and regulations. The report required under this subdivision shall be submitted within 30 days of the date that the chief executive officer, chief of staff, director, or administrator determines that such reasonable belief exists.

4. Any disciplinary proceeding begun by the institution, organization, facility, or provider as a result of conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this subdivision shall be submitted within 30 days of the date of written communication to the health professional notifying him of the initiation of a disciplinary proceeding.

5. Any disciplinary action taken during or at the conclusion of disciplinary proceedings or while under investigation, including but not limited to denial or termination of employment, denial or termination of privileges or restriction of privileges that results from conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v) substance abuse. The report required under this subdivision shall be submitted within 30 days of the date of written communication to the health professional notifying him of any disciplinary action.

6. The voluntary resignation from the staff of the health care institution, home health or hospice organization, assisted living facility, or provider, or voluntary restriction or expiration of privileges at the institution, organization, facility, or provider, of any health professional while such health professional is under investigation or is the subject of disciplinary proceedings taken or begun by the institution, organization, facility, or provider or a committee thereof for any reason related to possible intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, medical incompetence, unprofessional conduct, moral turpitude, mental or physical impairment, or substance abuse.

Any report required by this section shall be in writing directed to the Director of the Department of Health Professions or to the Director of the Office of Licensure and Certification at the Department of Health, shall give the name, address, and date of birth of the person who is the subject of the report and shall fully describe the circumstances surrounding the facts required to be reported. The report shall include the names and contact information of individuals with knowledge about the facts required to be reported and the names and contact information of individuals from whom the hospital or health care institution, organization, facility, or provider sought information to substantiate the facts required to be reported. All relevant medical records shall be attached to the report if patient care or the health professional's health status is at issue. The reporting hospital, health care institution, home health or hospice organization, assisted living facility, or provider shall also provide notice to the Department or the Office that it has submitted a report to the National Practitioner Data Bank under the Health Care Quality Improvement Act (42 U.S.C. § 11101 et seq.). The reporting hospital, health care institution, home health or hospice organization, assisted living facility, or provider shall give the health professional who is the subject of the report an opportunity to review the report. The health professional may submit a separate report if he disagrees with the substance of the report.

This section shall not be construed to require the hospital, health care institution, home health or hospice organization, assisted living facility, or provider to submit any proceedings, minutes, records, or reports that are privileged under § 8.01-581.17, except that the provisions of § 8.01-581.17 shall not bar (i) any report required by this section or (ii) any requested medical records that are necessary to investigate unprofessional conduct reported pursuant to this subtitle or unprofessional conduct that should have been reported pursuant to this subtitle. Under no circumstances shall compliance with this section be construed to waive or limit the privilege provided in § 8.01-581.17. No person or entity shall be obligated to report any matter to the Department or the Office if the person or entity has actual notice that the same matter has already been reported to the Department or the Office. No person or entity shall be obligated to report a health care provider who is participating in a professional program as described in subsection B of § 8.01-581.16 unless

there is a reasonable belief that the participant is not competent to continue to practice or is a danger to himself or to the health and welfare of his patients or the public.

B. The State Health Commissioner, Commissioner of Social Services, and Commissioner of Behavioral Health and Developmental Services shall report to the Department any information of which their agencies may become aware in the course of their duties that a health professional may be guilty of fraudulent, unethical, or unprofessional conduct as defined by the pertinent licensing statutes and regulations. However, the State Health Commissioner shall not be required to report information reported to the Director of the Office of Licensure and Certification pursuant to this section to the Department of Health Professions.

C. Any person making a report by this section, providing information pursuant to an investigation or testifying in a judicial or administrative proceeding as a result of such report shall be immune from any civil liability alleged to have resulted therefrom unless such person acted in bad faith or with malicious intent.

D. Medical records or information learned or maintained in connection with an alcohol or drug prevention function that is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall be exempt from the reporting requirements of this section to the extent that such reporting is in violation of 42 U.S.C. § 290dd-2 or regulations adopted thereunder.

E. Any person who fails to make a report to the Department as required by this section shall be subject to a civil penalty not to exceed $25,000 assessed by the Director. The Director shall report the assessment of such civil penalty to the Commissioner of Health, Commissioner of Social Services, or Commissioner of Behavioral Health and Developmental Services, as appropriate. Any person assessed a civil penalty pursuant to this section shall not receive a license or certification or renewal of such unless such penalty has been paid pursuant to § 32.1-125.01. The Medical College of Virginia Hospitals and the University of Virginia Hospitals shall not receive certification pursuant to § 32.1-137 ~~or Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1~~ unless such penalty has been paid.

§ 54.1-2937.1. Retiree license.

A. The Board may issue a retiree license to any doctor of medicine, osteopathy, podiatry, or chiropractic who holds an unrestricted, active license to practice in the Commonwealth upon receipt of a request and submission of the fee required by the Board. A person to whom a retiree license has been issued shall not be required to meet continuing competency requirements for the first biennial renewal of such license.

B. A person to whom a retiree license has been issued shall only engage in the practice of medicine, osteopathy, podiatry, or chiropractic for the purpose of providing (i) charity care, as defined in § ~~32.1-102.1~~ *32.1-3*, and (ii) health care services to patients in their residence for whom travel is a barrier to receiving medical care.

4. That the provisions of the first enactment of this act shall become effective on July 1, 2025.

5. That the provisions of the second enactment of this act shall become effective on July 1, 2026.

6. That the provisions of the third enactment of this act shall become effective on July 1, 2027.

7. That Article 1.1 (§§ 32.1-102.1 through 32.1-102.11) of Chapter 4 of Title 32.1 of the Code of Virginia is repealed effective July 1, 2027.