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HOUSE BILL NO. 300

Offered January 11, 2006

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A BILL to amend and reenact §§ 2.2-2818, 22.1-178, 32.1-46, 32.1-50, 32.1-60, 32.1-138, 32.1-325, 45.1-161.70, 45.1-161.292:43, 46.2-208, 46.2-322, 46.2-731, 46.2-1240, 46.2-1241, 53.1-22, 54.1-3812, 59.1-297, 59.1-298, 59.1-310.4, 63.2-1716 and 63.2-1808 of the Code of Virginia, and to amend the Code of Virginia by adding a section numbered 54.1-2951.4, relating to licensed physician assistants.

Patrons—Jones, S.C. and Watts

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 22.1-178, 32.1-46, 32.1-50, 32.1-60, 32.1-138, 32.1-325, 45.1-161.70, 45.1-161.292:43, 46.2-208, 46.2-322, 46.2-731, 46.2-1240, 46.2-1241, 53.1-22, 54.1-3812, 59.1-297, 59.1-298, 59.1-310.4, 63.2-1716 and 63.2-1808 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 54.1-2951.4 as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage 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 and may be limited to a benefit of \$50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean 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.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

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HB300

3. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be 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. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee; (ii) the treating health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive

breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than 48 hours 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 breast cancer. 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.

13. Include coverage (i) to persons age 50 and over and (ii) to 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.

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

15. Include provisions allowing employees to continue receiving health care services for a period of up to 90 days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least 90 days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

182 16. Include coverage for patient costs incurred during participation in clinical trials for treatment
183 studies on cancer, including ovarian cancer trials.

184 The reimbursement for patient costs incurred during participation in clinical trials for treatment
185 studies on cancer shall be determined in the same manner as reimbursement is determined for other
186 medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles,
187 copayments and coinsurance factors that are no less favorable than for physical illness generally.

188 For purposes of this subdivision:

189 "Cooperative group" means a formal network of facilities that collaborate on research projects and
190 have an established NIH-approved peer review program operating within the group. "Cooperative group"
191 includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer
192 Institute Community Clinical Oncology Program.

193 "FDA" means the Federal Food and Drug Administration.

194 "Multiple project assurance contract" means a contract between an institution and the federal
195 Department of Health and Human Services that defines the relationship of the institution to the federal
196 Department of Health and Human Services and sets out the responsibilities of the institution and the
197 procedures that will be used by the institution to protect human subjects.

198 "NCI" means the National Cancer Institute.

199 "NIH" means the National Institutes of Health.

200 "Patient" means a person covered under the plan established pursuant to this section.

201 "Patient cost" means the cost of a medically necessary health care service that is incurred as a result
202 of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not
203 include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the
204 treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research
205 associated with the clinical trial, or (iii) the cost of the investigational drug or device.

206 Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be
207 provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such
208 treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a
209 Phase I clinical trial.

210 The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

211 a. The National Cancer Institute;

212 b. An NCI cooperative group or an NCI center;

213 c. The FDA in the form of an investigational new drug application;

214 d. The federal Department of Veterans Affairs; or

215 e. An institutional review board of an institution in the Commonwealth that has a multiple project
216 assurance contract approved by the Office of Protection from Research Risks of the NCI.

217 The facility and personnel providing the treatment shall be capable of doing so by virtue of their
218 experience, training, and expertise.

219 Coverage under this subdivision shall apply only if:

220 (1) There is no clearly superior, noninvestigational treatment alternative;

221 (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will
222 be at least as effective as the noninvestigational alternative; and

223 (3) The patient and the physician or health care provider who provides services to the patient under
224 the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to
225 procedures established by the plan.

226 17. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a
227 covered employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered
228 employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized
229 guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours
230 referenced when the attending physician, in consultation with the covered employee, determines that a
231 shorter hospital stay is appropriate.

232 18. Include coverage for biologically based mental illness.

233 For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous
234 condition caused by a biological disorder of the brain that results in a clinically significant syndrome
235 that substantially limits the person's functioning; specifically, the following diagnoses are defined as
236 biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective
237 disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder,
238 attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

239 Coverage for biologically based mental illnesses shall neither be different nor separate from coverage
240 for any other illness, condition or disorder for purposes of determining deductibles, benefit year or
241 lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,
242 copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and
243 coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage 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. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

21. 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 employee provided coverage pursuant to this section, 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 employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

22. Include coverage 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 coverage shall include follow-up audiological examinations as recommended by a physician, *physician assistant*, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

305 "State employee" means state employee as defined in § 51.1-124.3; employee as defined in
306 § 51.1-201; the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301
307 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and
308 domestic relations, and district courts of the Commonwealth; and interns and residents employed by the
309 School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of
310 the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

311 "Part-time state employees" means classified or similarly situated employees in legislative, executive,
312 judicial or independent agencies who are compensated on a salaried basis and work at least 20 hours,
313 but less than 32 hours, per week.

314 E. Provisions shall be made for retired employees to obtain coverage under the above plan,
315 including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be
316 obligated to, pay all or any portion of the cost thereof.

317 F. Any self-insured group health insurance plan established by the Department of Human Resource
318 Management that utilizes a network of preferred providers shall not exclude any physician solely on the
319 basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets
320 the plan criteria established by the Department.

321 G. The plan shall include, in each planning district, at least two health coverage options, each
322 sponsored by unrelated entities. No later than July 1, 2006, one of the health coverage options to be
323 available in each planning district shall be a high deductible health plan that would qualify for a health
324 savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

325 In each planning district that does not have an available health coverage alternative, the Department
326 shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to
327 provide coverage under the plan.

328 This subsection shall not apply to any state agency authorized by the Department to establish and
329 administer its own health insurance coverage plan separate from the plan established by the Department.

330 H. Any self-insured group health insurance plan established by the Department of Human Resource
331 Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary
332 to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least
333 annually, and updated as necessary in consultation with and with the approval of a pharmacy and
334 therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists,
335 (ii) physicians, and (iii) other health care providers.

336 If the plan maintains one or more drug formularies, the plan shall establish a process to allow a
337 person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs
338 in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable
339 investigation and consultation with the prescriber, the formulary drug is determined to be an
340 inappropriate therapy for the medical condition of the person. The plan shall act on such requests within
341 one business day of receipt of the request.

342 I. Any plan established in accordance with this section requiring preauthorization prior to rendering
343 medical treatment shall have personnel available to provide authorization at all times when such
344 preauthorization is required.

345 J. Any plan established in accordance with this section shall provide to all covered employees written
346 notice of any benefit reductions during the contract period at least 30 days before such reductions
347 become effective.

348 K. No contract between a provider and any plan established in accordance with this section shall
349 include provisions that require a health care provider or health care provider group to deny covered
350 services that such provider or group knows to be medically necessary and appropriate that are provided
351 with respect to a covered employee with similar medical conditions.

352 L. The Department of Human Resource Management shall appoint an Ombudsman to promote and
353 protect the interests of covered employees under any state employee's health plan.

354 The Ombudsman shall:

355 1. Assist covered employees in understanding their rights and the processes available to them
356 according to their state health plan.

357 2. Answer inquiries from covered employees by telephone and electronic mail.

358 3. Provide to covered employees information concerning the state health plans.

359 4. Develop information on the types of health plans available, including benefits and complaint
360 procedures and appeals.

361 5. Make available, either separately or through an existing Internet web site utilized by the
362 Department of Human Resource Management, information as set forth in subdivision 4 and such
363 additional information as he deems appropriate.

364 6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the
365 disposition of each such matter.

366 7. Upon request, assist covered employees in using the procedures and processes available to them

from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification number, which shall be assigned to the covered employee and shall not be the same as the employee's social security number.

O. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

P. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least 30 days following the death of such state employee.

Q. The plan established in accordance with this section that follows a policy of sending its payment to the covered employee or covered family member for a claim for services received from a nonparticipating physician or osteopath shall (i) include language in the member handbook that notifies the covered employee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the covered employee or covered family member, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

§ 22.1-178. Requirements for persons employed to drive school buses.

A. No school board shall hire, employ, or enter into any agreement with any person for the purposes of operating a school bus transporting pupils unless the person proposed to so operate such school bus shall:

1. Have a physical examination of a scope prescribed by the Board of Education with the advice of the Medical Society of Virginia and furnish a form prescribed by the Board of Education showing the results of such examination.

2. Furnish a statement or copy of records from the Department of Motor Vehicles showing that the records of such Department do not disclose that the person, within the preceding five years, has been convicted upon a charge of driving under the influence of alcohol or drugs, convicted of a felony or assigned to any alcohol safety action program or driver alcohol rehabilitation program pursuant to § 18.2-271.1 or, within the preceding twelve months, has been convicted of two or more moving traffic violations or required to attend a driver improvement clinic by the Commissioner of the Department of Motor Vehicles pursuant to § 46.2-498.

3. Furnish a statement signed by two reputable persons who reside in the school division or in the applicant's community that the person is of good moral character.

4. Exhibit a license showing the person has successfully undertaken the examination prescribed by § 46.2-339.

5. Have reached the age of eighteen on the first day of the school year.

B. Any school board may require successful completion of the American National Red Cross first-aid course or its equivalent as a condition to employment to operate a school bus transporting pupils.

428 C. School boards may require persons accepting employment after July 1, 1994, as a driver of a
429 school bus transporting pupils to agree, as a condition of employment, to submit to alcohol and
430 controlled substance testing. Any such tests shall be conducted in compliance with Board of Education
431 regulations.

432 D. The documents required pursuant to subdivisions A 1 and A 2 of this section shall be furnished
433 annually prior to the anniversary date of the employment agreement as a condition to continuing
434 employment to operate a school bus.

435 E. The documents required pursuant to this section shall be filed with, and made a part of, the
436 records of the school board employing such person as a school bus operator.

437 F. The State Department of Education shall furnish to the several division superintendents the
438 necessary forms to be used by applicants in furnishing the information required by this section. Insofar
439 as practicable, such forms shall be designed to limit paperwork, avoid the possibility of mistake, and
440 furnish all parties involved with a complete and accurate record of the information required.

441 G. The physical examination required by subsection A may be performed and the report of the
442 results signed by a licensed nurse practitioner or physician assistant.

443 § 32.1-46. Immunization of patients against certain diseases.

444 A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth
445 shall cause such child to be immunized by vaccine against diphtheria, tetanus, whooping cough and
446 poliomyelitis before such child attains the age of one year, against Haemophilus influenzae type b before
447 he attains the age of 30 months, and against measles (rubeola), German measles (rubella) and mumps
448 before such child attains the age of two years. All children born on or after January 1, 1994, shall be
449 required to receive immunization against hepatitis B before their first birthday. All children shall also be
450 required to receive a second dose of measles (rubeola) vaccine in accordance with the regulations of the
451 Board. The Board's regulations shall require that all children receive a second dose of measles (rubeola)
452 vaccine prior to first entering kindergarten or first grade and that all children who have not yet received
453 a second dose of measles (rubeola) vaccine receive such second dose prior to entering the sixth grade.
454 All children born on or after January 1, 1997, shall be required to receive immunization against varicella
455 zoster (chicken pox), not earlier than the age of 12 months. Children who have evidence of immunity as
456 demonstrated by laboratory confirmation of immunity or a reliable medical history of disease are exempt
457 from such requirement. After July 1, 2001, all children who have not yet received immunization against
458 hepatitis B shall receive such immunization prior to entering sixth grade.

459 The parent, guardian or person standing in loco parentis may have such child immunized by a
460 physician or registered nurse or may present the child to the appropriate local health department, which
461 shall administer the required vaccines without charge.

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

466 C. The vaccines required by this section shall meet the standards prescribed in, and be administered
467 in accordance with, regulations of the Board.

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

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

472 2. The parent or guardian presents a statement from a physician licensed to practice medicine in
473 Virginia, or a licensed nurse practitioner, that states that the physical condition of the child is such that
474 the administration of one or more of the required immunizing agents would be detrimental to the health
475 of the child.

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

485 § 32.1-50. Examination of persons suspected of having active tuberculosis disease; reporting; report
486 forms; report schedule; laboratory reports and required samples.

487 A. Any local health director may request any person having or reasonably suspected of having active
488 tuberculosis disease to be examined immediately for the purpose of ascertaining the presence or absence
489 of the disease. Such examination may be made by any licensed physician, *physician assistant*, or

licensed nurse practitioner 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 nurse practitioner 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 nurse practitioner.

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 ensure testing for antimicrobial susceptibility on each initial isolate from a person with active tuberculosis disease; however, this requirement may be fulfilled by submission to the local health director of a report of antimicrobial drug susceptibilities performed by a laboratory certified by existing state or national agencies to perform such testing. The intention to file a written report shall be communicated to the local health director at the time the finding of a culture positive for tubercle bacilli is initially reported.

§ 32.1-60. Prenatal tests required.

Every physician, *physician assistant*, or nurse practitioner 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, *physician assistant*, licensed nurse practitioner, or clinic. Serological tests required by this section may be performed by the Department of General Services, Division of Consolidated Laboratory Services (DCLS).

§ 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, prior to or at the time of admission and during his stay, of services available in the facility and of 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 Health Care Financing Administration surveys and investigations, if any;

4. Is fully informed by a physician, *physician assistant*, or nurse practitioner of his medical condition unless medically contraindicated as documented by a physician, *physician assistant*, or nurse practitioner 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

551 Security Act, and is given reasonable advance notice as provided in § 32.1-138.1 to ensure orderly
552 transfer or discharge, and such actions are documented in his medical record;

553 6. Is encouraged and assisted, throughout the period of his stay, to exercise his rights as a patient
554 and as a citizen and to this end may voice grievances and recommend changes in policies and services
555 to facility staff and to outside representatives of his choice, free from restraint, interference, coercion,
556 discrimination, or reprisal;

557 7. May manage his personal financial affairs, or may have access to records of financial transactions
558 made on his behalf at least once a month and is given at least a quarterly accounting of financial
559 transactions made on his behalf should the facility accept his written delegation of this responsibility to
560 the facility for any period of time in conformance with state law;

561 8. Is free from mental and physical abuse and free from chemical and, except in emergencies,
562 physical restraints except as authorized in writing by a physician for a specified and limited period of
563 time or when necessary to protect the patient from injury to himself or to others;

564 9. Is assured confidential treatment of his personal and medical records and may approve or refuse
565 their release to any individual outside the facility, except in case of his transfer to another health care
566 institution or as required by law or third-party payment contract;

567 10. Is treated with consideration, respect, and full recognition of his dignity and individuality,
568 including privacy in treatment and in care for his personal needs;

569 11. Is not required to perform services for the facility that are not included for therapeutic purposes
570 in his plan of care;

571 12. May associate and communicate privately with persons of his choice and send and receive his
572 personal mail unopened, unless medically contraindicated as documented by his physician in his medical
573 record;

574 13. May meet with and participate in activities of social, religious and community groups at his
575 discretion, unless medically contraindicated as documented by his physician, *physician assistant*, or
576 nurse practitioner in his medical record;

577 14. May retain and use his personal clothing and possessions as space permits unless to do so would
578 infringe upon rights of other patients and unless medically contraindicated as documented by his
579 physician, *physician assistant*, or nurse practitioner in his medical record; and

580 15. If married, is assured privacy for visits by his or her spouse and if both are inpatients in the
581 facility, is permitted to share a room with such spouse unless medically contraindicated as documented
582 by the attending physician, *physician assistant*, or nurse practitioner in the medical record.

583 B. All established policies and procedures regarding the rights and responsibilities of patients shall be
584 printed in at least 12-point type and posted conspicuously in a public place in all nursing home facilities
585 required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter. These
586 policies and procedures shall include the name and telephone number of the complaint coordinator in the
587 Division of Licensure and Certification of the Virginia Department of Health, the Adult Protective
588 Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia
589 Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies
590 of such policies and procedures shall be given to patients upon admittance to the facility and made
591 available to patients currently in residence, to any guardians, next of kin, or sponsoring agency or
592 agencies, and to the public.

593 C. The provisions of this section shall not be construed to restrict any right that any patient in
594 residence has under law.

595 D. Each facility shall provide appropriate staff training to implement each patient's rights included in
596 subsection A hereof.

597 E. All rights and responsibilities specified in subsection A hereof and § 32.1-138.1 as they pertain to
598 (i) a patient adjudicated incapacitated in accordance with state law, (ii) a patient who is found, by his
599 physician, to be medically incapable of understanding these rights, or (iii) a patient who is unable to
600 communicate with others shall devolve to such patient's guardian, next of kin, sponsoring agency or
601 agencies, or representative payee, except when the facility itself is representative payee, selected
602 pursuant to section 205(j) of Title II of the United States Social Security Act.

603 F. Nothing in this section shall be construed to prescribe, regulate, or control the remedial care and
604 treatment or nursing service provided to any patient in a nursing institution to which the provisions of
605 § 32.1-128 are applicable.

606 G. It shall be the responsibility of the Commissioner to insure that the provisions of this section and
607 the provisions of § 32.1-138.1 are observed and implemented by nursing home facilities. Each nursing
608 home facility to which this section and § 32.1-138.1 are applicable shall certify to the Commissioner that
609 it is in compliance with the provisions of this section and the provisions of § 32.1-138.1 as a condition
610 to the issuance or renewal of the license required by Article 1 (§ 32.1-123 et seq.) of this chapter.

611 § 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human
612 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 Secretary of the United States Department 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;

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

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

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

13. A provision for payment of medical assistance which provides for payment for 48 hours of

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

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

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

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

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

18. A provision for payment of medical assistance services for liver, heart and lung transplantation procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational; (iii) prior authorization by the Department of Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant center where the surgery is proposed to be performed have been used by the transplant team or program to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living;

19. A provision for payment of medical assistance for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations;

20. A provision for payment of medical assistance for custom ocular prostheses;

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

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

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

24. A provision, consistent with federal law, to establish a long-term care partnership program that shall encourage the private purchase of long-term care insurance as the primary source of funding the participant's long-term care. Such program shall provide protection from estate recovery as authorized by federal law.

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, 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 with any provider who has been convicted of a felony.

4. Refuse to enter into or renew an 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 a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a

797 hearing in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) regarding the provider's
798 participation in the conduct resulting in the conviction.

799 The Director's decision upon reconsideration shall be consistent with federal and state laws. The
800 Director may consider the nature and extent of any adverse impact the agreement or contract denial or
801 termination may have on the medical care provided to Virginia Medicaid recipients.

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

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

816 H. The Department of Medical Assistance Services shall:

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

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

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

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

836 § 45.1-161.70. Qualification for crew membership; direction of crews.

837 A. To qualify for membership in mine rescue crews an applicant shall be an experienced miner and
838 shall pass a physical examination by a licensed physician, *physician assistant*, or licensed nurse
839 practitioner at least annually. A record that such examination was taken shall be kept on file by the
840 operator who employs the crew members and a copy shall be furnished to the Director.

841 B. All rescue or recovery work performed by these crews shall be under the jurisdiction of the
842 Department. The Department shall consult with company officials, representatives of the Mine Safety
843 and Health Administration and representatives of the miners, and all should be in agreement as far as
844 possible on the proper procedure for rescue and recovery; however, the Chief in his discretion may take
845 full responsibility in directing such work. Procedures for use of apparatus or equipment shall be guided
846 by the mine rescue apparatus and auxiliary equipment manuals.

847 § 45.1-161.292:43. Qualification for crew membership; direction of crews.

848 A. To qualify for membership in mine rescue crews, an applicant shall (i) be an experienced miner,
849 (ii) be not more than 50 years of age, and (iii) pass a physical examination by a licensed physician,
850 *licensed physician assistant*, or licensed nurse practitioner at least annually. A record that such
851 examination was taken shall be kept on file by the operator who employs the crew members and a copy
852 shall be furnished to the Director.

853 B. All rescue or recovery work performed by these crews shall be under the jurisdiction of the
854 Department. The Department shall consult with company officials, representatives of the Mine Safety
855 and Health Administration and representatives of the miners, and all should be in agreement as far as
856 possible on the proper procedure for rescue and recovery; however, the Director in his discretion may
857 take full responsibility in directing such work. In all instances, procedures shall be guided by the mine
858 rescue apparatus and auxiliary equipment manuals.

§ 46.2-208. Records of Department; when open for inspection; release of privileged information.
A. All records in the office of the Department containing the specific classes of information outlined below shall be considered privileged records:

1. Personal information, including all data defined as "personal information" in § 2.2-3801;
2. Driver information, including all data that relates to driver's license status and driver activity; and
3. Vehicle information, including all descriptive vehicle data and title, registration, and vehicle activity data.

B. The Commissioner shall release such information only under the following conditions:

1. Notwithstanding other provisions of this section, medical data included in personal data shall be released only to a physician, *physician assistant*, or nurse practitioner as provided in § 46.2-322.

2. Insurance data may be released as specified in §§ 46.2-372, 46.2-380, and 46.2-706.

3. Notwithstanding other provisions of this section, information disclosed or furnished shall be assessed a fee as specified in § 46.2-214.

4. When the person requesting the information is (i) the subject of the information, (ii) the parent or guardian of the subject of the information, (iii) the authorized representative of the subject of the information, or (iv) the owner of the vehicle that is the subject of the information, the Commissioner shall provide him with the requested information and a complete explanation of it. Requests for such information need not be made in writing or in person and may be made orally or by telephone, provided that the Department is satisfied that there is adequate verification of the requester's identity. When so requested in writing by (a) the subject of the information, (b) the parent or guardian of the subject of the information, (c) the authorized representative of the subject of the information, or (d) the owner of the vehicle that is the subject of the information, the Commissioner shall verify and, if necessary, correct the personal information provided and furnish driver and vehicle information in the form of an abstract of the record.

5. On the written request of any insurance carrier, surety, or representative of an insurance carrier or surety, the Commissioner shall furnish such insurance carrier, surety, or representative an abstract of the record of any person subject to the provisions of this title. The abstract shall include any record of any conviction of a violation of any provision of any statute or ordinance relating to the operation or ownership of a motor vehicle or of any injury or damage in which he was involved and a report of which is required by § 46.2-372. No such report of any conviction or accident shall be made after 60 months from the date of the conviction or accident unless the Commissioner or court used the conviction or accident as a reason for the suspension or revocation of a driver's license or driving privilege, in which case the revocation or suspension and any conviction or accident pertaining thereto shall not be reported after 60 months from the date that the driver's license or driving privilege has been reinstated. This abstract shall not be admissible in evidence in any court proceedings.

6. On the written request of any business organization or its agent, in the conduct of its business, the Commissioner shall compare personal information supplied by the business organization or agent with that contained in the Department's records and, when the information supplied by the business organization or agent is different from that contained in the Department's records, provide the business organization or agent with correct information as contained in the Department's records. Personal information provided under this subdivision shall be used solely for the purpose of pursuing remedies that require locating an individual.

7. The Commissioner shall provide vehicle information to any business organization or agent on such business' or agent's written request. Disclosures made under this subdivision shall not include any personal information and shall not be subject to the limitations contained in subdivision 6 of this subsection.

8. On the written request of any motor vehicle rental or leasing company or its designated agent, the Commissioner shall (i) compare personal information supplied by the company or agent with that contained in the Department's records and, when the information supplied by the company or agent is different from that contained in the Department's records, provide the company or agent with correct information as contained in the Department's records and (ii) provide the company or agent with driver information in the form of an abstract of any person subject to the provisions of this title. Such abstract shall include any record of any conviction of a violation of any provision of any statute or ordinance relating to the operation or ownership of a motor vehicle or of any injury or damage in which the subject of the abstract was involved and a report of which is required by § 46.2-372. No such abstract shall include any record of any conviction or accident more than 60 months after the date of such conviction or accident unless the Commissioner or court used the conviction or accident as a reason for the suspension or revocation of a driver's license or driving privilege, in which case the revocation or suspension and any conviction or accident pertaining thereto shall cease to be included in such abstract after 60 months from the date on which the driver's license or driving privilege was reinstated. No abstract released under this subdivision shall be admissible in evidence in any court proceedings.

920 9. On the request of any federal, state, or local governmental entity, law-enforcement officer, attorney
921 for the Commonwealth, court, or the authorized agent of any of the foregoing, the Commissioner shall
922 (i) compare personal information supplied by the governmental entity, officer, attorney for the
923 Commonwealth, court, or the authorized agent of any of the foregoing, with that contained in the
924 Department's records and, when the information supplied by the governmental entity, officer, attorney
925 for the Commonwealth, court, or the authorized agent of any of the foregoing, is different from that
926 contained in the Department's records, provide the governmental entity, officer, attorney for the
927 Commonwealth, court, or the authorized agent of any of the foregoing, with correct information as
928 contained in the Department's records and (ii) provide driver and vehicle information in the form of an
929 abstract of the record showing all convictions, accidents, driver's license suspensions or revocations, and
930 other appropriate information as the governmental entity, officer, attorney for the Commonwealth, court,
931 or the authorized agent of any of the foregoing, may require in order to carry out its official functions.

932 10. On request of the driver licensing authority in any other state or foreign country, the
933 Commissioner shall provide whatever classes of information the requesting authority shall require in
934 order to carry out its official functions.

935 11. On the written request of any employer, prospective employer, or authorized agent of either, and
936 with the written consent of the individual concerned, the Commissioner shall (i) compare personal
937 information supplied by the employer, prospective employer, or agent with that contained in the
938 Department's records and, when the information supplied by the employer, prospective employer, or
939 agent is different from that contained in the Department's records, provide the employer, prospective
940 employer, or agent with correct information as contained in the Department's records and (ii) provide the
941 employer, prospective employer, or agent with driver information in the form of an abstract of an
942 individual's record showing all convictions, accidents, driver's license suspensions or revocations, and
943 any type of driver's license that the individual currently possesses, provided that the individual's position
944 or the position that the individual is being considered for involves the operation of a motor vehicle.

945 12. On the written request of any member of or applicant for membership in a volunteer fire
946 company or volunteer rescue squad, the Commissioner shall (i) compare personal information supplied
947 by the volunteer fire company or volunteer rescue squad with that contained in the Department's records
948 and, when the information supplied by the volunteer fire company or volunteer rescue squad is different
949 from that contained in the Department's records, provide the volunteer fire company or volunteer rescue
950 squad with correct information as contained in the Department's records and (ii) provide driver
951 information in the form of an abstract of the member's or applicant's record showing all convictions,
952 accidents, license suspensions or revocations, and any type of driver's license that the individual
953 currently possesses. Such abstract shall be provided free of charge if the request is accompanied by
954 appropriate written evidence that the person is a member of or applicant for membership in a volunteer
955 fire company or volunteer rescue squad and the abstract is needed by a volunteer fire company or
956 volunteer rescue squad to establish the qualifications of the member or applicant to operate equipment
957 owned by the volunteer fire company or volunteer rescue squad.

958 13. On the written request of any person who has applied to be a volunteer with a Virginia affiliate
959 of Big Brothers/Big Sisters of America, the Commissioner shall (i) compare personal information
960 supplied by a Virginia affiliate of Big Brothers/Big Sisters of America with that contained in the
961 Department's records and, when the information supplied by a Virginia affiliate of Big Brothers/Big
962 Sisters of America is different from that contained in the Department's records, provide the Virginia
963 affiliate of Big Brothers/Big Sisters of America with correct information as contained in the
964 Department's records and (ii) provide driver information in the form of an abstract of the applicant's
965 record showing all convictions, accidents, license suspensions or revocations, and any type of driver's
966 license that the individual currently possesses. Such abstract shall be provided free of charge if the
967 request is accompanied by appropriate written evidence that the person has applied to be a volunteer
968 with a Virginia affiliate of Big Brothers/Big Sisters of America.

969 14. On the written request of any person who has applied to be a volunteer with a court-appointed
970 special advocate program pursuant to § 9.1-153, the Commissioner shall provide an abstract of the
971 applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of
972 driver's license that the individual currently possesses. Such abstract shall be provided free of charge if
973 the request is accompanied by appropriate written evidence that the person has applied to be a volunteer
974 with a court-appointed special advocate program pursuant to § 9.1-153.

975 15. Upon the request of any employer, prospective employer, or authorized representative of either,
976 the Commissioner shall (i) compare personal information supplied by the employer, prospective
977 employer, or agent with that contained in the Department's records and, when the information supplied
978 by the employer, prospective employer, or agent is different from that contained in the Department's
979 records, provide the employer, prospective employer, or agent with correct information as contained in
980 the Department's records and (ii) provide driver information in the form of an abstract of the driving
981 record of any individual who has been issued a commercial driver's license, provided that the

individual's position or the position that the individual is being considered for involves the operation of a commercial motor vehicle. Such abstract shall show all convictions, accidents, license suspensions, revocations, or disqualifications, and any type of driver's license that the individual currently possesses.

16. Upon the receipt of a completed application and payment of applicable processing fees, the Commissioner may enter into an agreement with any governmental authority or business to exchange information specified in this section by electronic or other means.

17. Upon the request of an attorney representing a person in a motor vehicle accident, the Commissioner shall provide vehicle information, including the owner's name and address, to the attorney.

18. Upon the request, in the course of business, of any authorized representative of an insurance company or of any not-for-profit entity organized to prevent and detect insurance fraud, or perform rating and underwriting activities, the Commissioner shall provide to such person (i) all vehicle information, including the owner's name and address, descriptive data and title, registration, and vehicle activity data as requested or (ii) all driver information including name, license number and classification, date of birth, and address information for each driver under the age of 22 licensed in the Commonwealth of Virginia meeting the request criteria designated by such person, with such request criteria consisting of driver's license number or address information. No such information shall be used for solicitation of sales, marketing, or other commercial purposes.

19. Upon the request of an officer authorized to issue criminal warrants, for the purpose of issuing a warrant for arrest for unlawful disposal of trash or refuse in violation of § 33.1-346, the Commissioner shall provide vehicle information, including the owner's name and address.

20. Upon written request of the compliance agent of a private security services business, as defined in § 9.1-138, which is licensed by the Department of Criminal Justice Services, the Commissioner shall provide the name and address of the owner of the vehicle under procedures determined by the Commissioner.

21. Upon the request of the operator of a toll facility, or an authorized agent or employee of a toll facility operator, for the purpose of obtaining vehicle owner data under subsection I of § 46.2-819.1.

22. On the written request of any person who has applied to be a volunteer with a Virginia affiliate of Compeer, the Commissioner shall (i) compare personal information supplied by a Virginia affiliate of Compeer with that contained in the Department's records and, when the information supplied by a Virginia affiliate of Compeer is different from that contained in the Department's records, provide the Virginia affiliate of Compeer with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person has applied to be a volunteer with a Virginia affiliate of Compeer.

23. Upon the request of the Department of Environmental Quality for the purpose of obtaining vehicle owner data in connection with enforcement actions involving on-road testing of motor vehicles, pursuant to § 46.2-1178.1.

24. On the written request of any person who has applied to be a volunteer vehicle operator with a Virginia chapter of the American Red Cross, the Commissioner shall (i) compare personal information supplied by a Virginia chapter of the American Red Cross with that contained in the Department's records and, when the information supplied by a Virginia chapter of the American Red Cross is different from that contained in the Department's records, provide the Virginia chapter of the American Red Cross with correct information as contained in the Department's records and (ii) provide driver information in the form of an abstract of the applicant's record showing all convictions, accidents, license suspensions or revocations, and any type of driver's license that the individual currently possesses. Such abstract shall be provided free of charge if the request is accompanied by appropriate written evidence that the person has applied to be a volunteer vehicle operator with a Virginia chapter of the American Red Cross.

C. Whenever the Commissioner issues an order to suspend or revoke the driver's license or driving privilege of any individual, he may notify the National Driver Register Service operated by the United States Department of Transportation and any similar national driver information system and provide whatever classes of information the authority may require.

D. Accident reports may be inspected under the provisions of §§ 46.2-379 and 46.2-380.

E. Whenever the Commissioner takes any licensing action pursuant to the provisions of the Virginia Commercial Driver's License Act (§ 46.2-341.1 et seq.), he may provide information to the Commercial Driver License Information System, or any similar national commercial driver information system, regarding such action.

F. In addition to the foregoing provisions of this section, vehicle information may also be inspected

under the provisions of §§ 43-33, 43-34, 46.2-633, and §§ 46.2-1200.1 through 46.2-1237.

G. The Department may promulgate regulations to govern the means by which personal, vehicle, and driver information is requested and disseminated.

H. Driving records of any person accused of an offense involving the operation of a motor vehicle shall be provided by the Commissioner upon request to any person acting as counsel for the accused. If such counsel is from the public defender's office or has been appointed by the court, such records shall be provided free of charge.

I. The Department shall maintain the records of persons convicted of violations of § 18.2-36.2, subsection B of § 29.1-738, and §§ 29.1-738.02, 29.1-738.2, and 29.1-738.4 which shall be forwarded by every general district court or circuit court or the clerk thereof, pursuant to § 46.2-383. Such records shall be electronically available to any law-enforcement officer as provided for under clause (ii) of subdivision B 9.

§ 46.2-322. Examination of licensee believed incompetent; suspension, or restriction of license; license application to include questions as to physical or mental conditions of applicant; false answers; examination of applicant; physician's, physician assistant's, or nurse practitioner's statement.

A. If the Department has good cause to believe that a driver is incapacitated and therefore unable to drive a motor vehicle safely, after written notice of at least 15 days to the person, it may require him to submit to an examination to determine his fitness to drive a motor vehicle. If the driver so requests in writing, the Department shall give the Department's reasons for the examination, including the identity of all persons who have supplied information to the Department regarding the driver's fitness to drive a motor vehicle. However, the Department shall not supply the reasons or information if its source is a relative of the driver or a physician, *physician assistant*, or nurse practitioner, a pharmacist, or another licensed medical professional as defined in § 38.2-602 treating, or prescribing medications for, the driver.

B. As a part of its examination, the Department may require a physical examination by a licensed physician, *physician assistant*, or licensed nurse practitioner and a report on the results thereof. When it has completed its examination, the Department shall take whatever action may be appropriate and may suspend the license or privilege to drive a motor vehicle in the Commonwealth of the person or permit him to retain his license or privilege to drive a motor vehicle in the Commonwealth, or may issue a license subject to the restrictions authorized by § 46.2-329. Refusal or neglect of the person to submit to the examination or comply with restrictions imposed by the Department shall be grounds for suspension of his license or privilege to drive a motor vehicle in the Commonwealth.

C. The Commissioner shall include, as a part of the application for an original driver's license, or renewal thereof, questions as to the existence of physical or mental conditions that impair the ability of the applicant to drive a motor vehicle safely. Any person knowingly giving a false answer to any such question shall be guilty of a Class 2 misdemeanor. If the answer to any such question indicates the existence of such condition, the Commissioner shall require an examination of the applicant by a licensed physician, *physician assistant*, or licensed nurse practitioner as a prerequisite to the issuance of the driver's license. The report of the examination shall contain a statement that, in the opinion of the physician, *physician assistant*, or nurse practitioner, the applicant's physical or mental condition at the time of the examination does or does not preclude his safe driving of motor vehicles.

§ 46.2-731. Disabled parking license plates; owners of vehicles specially equipped and used to transport persons with disabilities; fees.

On receipt of an application, the Commissioner shall issue appropriately designed disabled parking license plates to persons with physical disabilities that limit or impair their ability to walk or that create a concern for his safety while walking or to the parents or legal guardians of such persons. The Commissioner shall request that the application be accompanied by a certification of a licensed physician or *physician assistant* that the applicant meets the definition of "person with a disability that limits or impairs his ability to walk" contained in § 46.2-1240. The issuance of a disabled parking license plate shall not preclude the issuance of a permanent removable windshield placard.

On application of an organization, the Commissioner shall issue disabled parking license plates for vehicles registered in the applicant's name if the vehicles are primarily used to transport persons with disabilities. The application shall include a certification by the applicant, under criteria determined by the Commissioner, that the vehicle is primarily used to transport persons with disabilities that limit or impair their ability to walk, as defined in § 46.2-1240.

The fee for the issuance of a disabled parking license plate under this section may not exceed the fee charged for a similar license plate for the same class vehicle.

§ 46.2-1240. Definitions.

"Disabled parking sign" means any sign used to identify parking spaces for use by vehicles bearing valid organizational, permanent, or temporary removable windshield placards, disabled parking license plates, or disabled parking license plates issued under § 46.2-739. All disabled parking signs shall be erected and maintained in accordance with signage requirements specified in § 36-99.11.

"Organizational removable windshield placard" means a two-sided, hooked placard which includes on each side: (i) the international symbol of access at least three inches in height, centered on the placard, and shown in white on a green background; (ii) the name of the institution or organization; (iii) an identification number; (iv) an expiration date imprinted on the placard and indicated by a month and year hole-punch system or an alternative system designed by the Department; (v) a misuse hotline number designated by the Department; (vi) a warning of the penalties for placard misuse; and (vii) the seal or identifying symbol of the issuing authority.

"Permanent removable windshield placard" means a two-sided, hooked placard which includes on each side: (i) the international symbol of access at least three inches in height, centered on the placard, and shown in white on a blue background; (ii) the name, age, and sex of the person to whom issued; (iii) an identification number; (iv) an expiration date imprinted on the placard and indicated by a month and year hole-punch system or an alternative system designed by the Department; (v) a misuse hotline number designated by the Department; (vi) a warning of the penalties for placard misuse; and (vii) the seal or other identifying symbol of the issuing authority. However, the person to whom the placard is issued may cover his name and/or age, as shown on the placard, with opaque, removable tape, provided that no other data on the placard is covered or obscured by such tape.

"Person with a disability that limits or impairs his ability to walk or that creates a concern for his safety while walking" means a person who, as determined by a licensed physician, podiatrist, or chiropractor: (i) cannot walk 200 feet without stopping to rest; (ii) cannot walk without the use of or assistance from a brace, cane, crutch, another person, prosthetic device, wheelchair, or other assistive device; (iii) is restricted by lung disease to such an extent that his forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or when at rest, his arterial oxygen tension is less than 60 millimeters of mercury on room air; (iv) uses portable oxygen; (v) has a cardiac condition to the extent that his functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association; (vi) is severely limited in his ability to walk due to an arthritic, neurological, or orthopedic condition; (vii) has some other debilitating condition that, in the view of a licensed physician, *physician assistant*, podiatrist, or chiropractor, limits or impairs his ability to walk; (viii) has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder; (ix) has been diagnosed with Alzheimer's disease or another form of dementia; (x) is legally blind or deaf; or (xi) has some other condition that, in the view of a licensed physician creates a safety concern while walking because of impaired judgment or other physical, developmental, or mental limitation. For the purposes of this definition, a determination of a disability by a podiatrist or chiropractor shall be limited to those conditions specified in items (i), (ii), (vi) or (vii) of this definition and shall be valid only for the issuance of temporary placards under subsection B of § 46.2-1241.

Any physician, *physician assistant*, podiatrist, or chiropractor certifying an applicant's disability under clause (vii) of this definition shall specify, in a space provided on the certification form, the medical condition that limits or impairs his patient's ability to walk. Any physician certifying a patient's disability under clause (xi) of this definition shall specify, in a space provided on the certification form, the physical, developmental, or mental condition that creates the safety concern.

"Temporary removable windshield placard" means a two-sided, hooked placard which includes on each side: (i) the international symbol of access at least three inches in height, centered on the placard, and shown in white on a red background; (ii) the name, age, and sex of the person to whom issued; (iii) an identification number; (iv) an expiration date imprinted on the placard and indicated by a month and year hole-punch system or an alternative system designed by the Department; (v) a misuse hotline number; (vi) a warning of the penalties for placard misuse; and (vii) the seal or other identifying symbol of the issuing authority. However, the person to whom the placard is issued may cover his name and/or age, as shown on the placard, with opaque, removable tape, provided that no other data on the placard is covered or obscured by such tape.

§ 46.2-1241. Issuance of disabled parking placards.

A. Upon application of a person with a disability that limits or impairs his ability to walk or that creates a concern for his safety while walking, the Commissioner shall issue a permanent removable windshield placard for use on a passenger car or pickup or panel truck. The Commissioner shall require that each original application be accompanied by a certification from a licensed physician or a *physician assistant* on forms prescribed by the Commissioner that the applicant meets the definition of "person with a disability that limits or impairs his ability to walk or that creates a concern for his safety while walking" contained in § 46.2-1240.

1. The Commissioner shall provide for the renewal of such placards every five years. Applications for renewals may require the applicant to certify that his disability is a permanent disability, but renewal applications need not be accompanied by a physician's certification of the applicant's disability. The Commissioner shall work in consultation with the Medical Advisory Board for the Department to

1166 develop a definition of "permanent disability" as used in this subdivision. Notwithstanding any contrary
1167 provision of this chapter, no physician's certification of an applicant's disability shall be required for the
1168 renewal of any disabled parking placard of an applicant to whom disabled parking license plates have
1169 been issued under § 46.2-731.

1170 2. The Commissioner shall charge a reasonable fee for each placard, but no fee shall be charged any
1171 person exempted from fees in § 46.2-739.

1172 3. The placards shall be of a design approved by the Commissioner pursuant to the specifications and
1173 definitions contained in § 46.2-1240.

1174 B. Upon the application of a person with a disability that limits or impairs his ability to walk and
1175 whose disability is temporary, the Commissioner shall issue a temporary removable windshield placard.
1176 The application for a temporary removable windshield placard shall be accompanied by a certification
1177 from a licensed physician, podiatrist, or chiropractor on forms prescribed by the Commissioner that the
1178 applicant meets the definition of "person with a condition that limits or impairs his ability to walk"
1179 contained in § 46.2-1240 and shall also include the period of time that the physician, podiatrist, or
1180 chiropractor determines the applicant will have the disability, not to exceed six months.

1181 1. The temporary removable windshield placard shall be valid for the period of time for which the
1182 physician, podiatrist, or chiropractor has determined that the applicant will have the disability, not to
1183 exceed six months from the date of issuance.

1184 2. The Commissioner shall provide for a reasonable fee to be charged for the placard. The placards
1185 shall be of a design approved by the Commissioner pursuant to the specifications and definitions
1186 contained in § 46.2-1240.

1187 C. On application, the Commissioner shall issue to hospitals, hospices, nursing homes, and other
1188 institutions and organizations meeting criteria determined by the Commissioner organizational removable
1189 windshield placards, as provided for in the foregoing provisions of this section, for use by volunteers
1190 when transporting disabled persons in passenger vehicles and pickup or panel trucks owned by such
1191 volunteers. The provisions of this section relating to other windshield placards issued under this section
1192 shall also apply, mutatis mutandis, to windshield placards issued to these institutions and organizations,
1193 except that windshield placards issued to institutions and agencies, in addition to their expiration date,
1194 shall bear the name of the institution or organization whose volunteers will be using the windshield
1195 placards rather than the name, age, and sex of the person to whom issued.

1196 1. The Commissioner shall provide for the renewal of such placards every five years.

1197 2. The placards shall be of a design approved by the Commissioner pursuant to the specifications and
1198 definitions contained in § 46.2-1240.

1199 D. No person shall use or display an organizational removable windshield placard, permanent
1200 removable windshield placard or temporary removable windshield placard beyond its expiration date.

1201 E. Organizational removable windshield placards, permanent removable windshield placards and
1202 temporary removable windshield placards shall be displayed in such a manner that they may be viewed
1203 from the front and rear of the vehicle and be hanging from the rearview mirror of a vehicle utilizing a
1204 parking space reserved for persons with disabilities that limit or impair their ability to walk. When there
1205 is no rearview mirror, the placard shall be displayed on the vehicle's dashboard. No placard shall be
1206 displayed from the rearview mirror while a vehicle is in motion.

1207 § 53.1-22. Misdemeanant suspected of having contagious disease.

1208 Whenever any court shall have reason to believe that a person convicted by it of a misdemeanor who
1209 is sentenced to serve time in a local correctional facility is afflicted with any contagious or infectious
1210 disease dangerous to the public health, the court shall have such person examined by a licensed
1211 physician, *physician assistant*, or licensed nurse practitioner. If the examination reveals the person is
1212 afflicted with such disease, the court may commit the person directly to the Department.

1213 § 54.1-2951.4. *When physician assistant signature accepted.*

1214 *Whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or*
1215 *endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification,*
1216 *affidavit or endorsement by a physician assistant.*

1217 § 54.1-3812. Release of records.

1218 A. A veterinarian licensed by the Board shall release or authorize the release of rabies immunization
1219 records and other relevant treatment data of an animal under his care to a requesting physician,
1220 *physician assistant*, or nurse practitioner who is contemplating the administration of the rabies treatment
1221 protocol to any person under his care who has been the victim of a bite or traumatic injury to the skin
1222 or body from such animal.

1223 B. Any veterinarian licensed by the Board who in good faith releases or authorizes the release of an
1224 animal's rabies immunization records and other relevant data pursuant to this section shall not be liable
1225 for civil damages resulting from the release of such information.

1226 § 59.1-297. Right of cancellation.

1227 A. Every health spa contract for the sale of health spa services may be cancelled under the following

circumstances:

1. A buyer may cancel the contract without penalty within three business days of its making and, upon notice to the health spa of the buyer's intent to cancel, shall be entitled to receive a refund of all moneys paid under the contract.

2. A buyer may cancel the contract if the health spa relocates or goes out of business and fails to provide comparable alternate facilities within five driving miles of the location designated in the health spa contract. Upon receipt of notice of the buyer's intent to cancel, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1.

3. The contract may be cancelled if the buyer dies or becomes physically unable to use a substantial portion of the services for 30 or more consecutive days. If the buyer becomes physically unable to use a substantial portion of the services for 30 or more consecutive days and wishes to cancel his contract, he must provide the health spa with a signed statement from his doctor, *physician assistant*, or nurse practitioner verifying that he is physically unable to use a substantial portion of the health spa services for 30 or more consecutive days. Upon receipt of notice of the buyer's intent to cancel, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1. In the case of disability, the health spa may require the buyer to submit to a physical examination by a doctor, *physician assistant*, or nurse practitioner agreeable to the buyer and the health spa within 30 days of receipt of notice of the buyer's intent to cancel. The cost of the examination shall be borne by the health spa.

B. The buyer shall notify the health spa of cancellation in writing, by certified mail, return receipt requested, or personal delivery, to the address of the health spa as specified in the health spa contract.

C. If the customer has executed any credit or lien agreement with the health spa or its representatives or agents to pay for all or part of health spa services, any such negotiable instrument executed by the buyer shall be returned to the buyer within 30 days after such cancellation.

D. If the spa agrees to allow a consumer to cancel for any other reason not outlined in this section, upon receipt of notice of cancellation by the buyer, the health spa shall refund to the buyer funds paid or accepted in payment of the contract in an amount computed as prescribed in § 59.1-297.1.

§ 59.1-298. Notice to buyer.

A copy of the executed health spa contract shall be delivered to the buyer at the time the contract is executed. All health spa contracts shall (i) be in writing, (ii) be signed by the buyer, (iii) designate the date on which the buyer actually signed the contract, (iv) state the starting and expiration dates of the initial membership period, (v) separately identify any initiation fee, (vi) either in the contract itself or in a separate notice provided to the buyer at the time the contract is executed, notify each buyer that the buyer should attempt to resolve with the health spa any complaint the buyer has with the health spa, and that the Virginia Department of Agriculture and Consumer Services, Office of Consumer Affairs regulates health spas in the Commonwealth pursuant to the provisions of the Virginia Health Spa Act, and (vii) contain the provisions set forth in § 59.1-297 under a conspicuous caption: "BUYER'S RIGHT TO CANCEL" that shall read substantially as follows:

If you wish to cancel this contract, you may cancel by making or delivering written notice to this health spa. The notice must say that you do not wish to be bound by the contract and must be delivered or mailed before midnight of the third business day after you sign this contract. The notice must be delivered or mailed to:

(Health spa shall insert its name and mailing address.)

If canceled within three business days, you will be entitled to a refund of all moneys paid. You may also cancel this contract if this spa goes out of business or relocates and fails to provide comparable alternate facilities within five driving miles of the location designated in this contract. You may also cancel if you become physically unable to use a substantial portion of the health spa services for 30 or more consecutive days, and your estate may cancel in the event of your death. You must prove you are unable to use a substantial portion of the health spa services by a doctor's, *physician assistant's*, or nurse

practitioner's certificate, and the health spa may also require that you submit to a physical examination, within 30 days of the notice of cancellation, by a doctor, *physician assistant*, or nurse practitioner agreeable to you and the

health spa. If you cancel after the three business days, the health spa may

1287 retain or collect a portion of the contract price equal to the proportionate
1288 value of the services or use of facilities you have already received. Any
1289 refund due to you shall be paid within 30 days of the effective date of
1290 cancellation.

1291 § 59.1-310.4. Warning signs.

1292 A. A tanning facility shall post a warning sign in a conspicuous location where it is readily readable
1293 by persons entering the establishment. The sign shall contain the following warning:

1294 DANGER: ULTRAVIOLET RADIATION

1295 Repeated exposure to ultraviolet radiation may cause chronic sun damage
1296 to the skin characterized by wrinkling, dryness, fragility, and bruising of
1297 the skin, and skin cancer.

1298 Failure to use protective eyewear may result in severe burns or
1299 permanent injury to the eyes.

1300 Medications or cosmetics may increase your sensitivity to ultraviolet
1301 radiation. Consult a physician, *physician assistant*, or nurse practitioner be-
1302 fore using a sunlamp if

1303 you are using medications, have a history of skin problems, or believe you
1304 are especially sensitive to sunlight. Pregnant women or women taking oral
1305 contraceptives who use this product may develop discolored skin.

1306 IF YOU DO NOT TAN IN THE SUN, YOU WILL NOT TAN FROM USE OF AN ULTRAVIOLET
1307 SUNLAMP.

1308 B. A tanning facility shall post a warning sign, one sign for each tanning
1309 device, in a conspicuous location that is readily readable to a person about
1310 to use the device. The sign shall contain the following:

1311 DANGER: ULTRAVIOLET RADIATION

1312 1. Follow the manufacturer's instructions for use of this device.

1313 2. Avoid too frequent or lengthy exposure. As with natural sunlight,
1314 exposure can cause serious eye and skin injuries and allergic reactions.
1315 Repeated exposure may cause skin cancer.

1316 3. Wear protective eyewear. Failure to use protective eyewear may result
1317 in severe burns or permanent damage to the eyes.

1318 4. Do not sunbathe before or after exposure to ultraviolet radiation
1319 from sunlamps.

1320 5. Medications or cosmetics may increase your sensitivity to ultraviolet
1321 radiation. Consult a physician, *physician assistant*, or nurse practitioner b-
1322 efore using a sunlamp

1323 if you are using medication, have a history of skin problems, or believe you
1324 are especially sensitive to sunlight. Pregnant women or women using oral
1325 contraceptives who use this product may develop discolored skin.

1326 IF YOU DO NOT TAN IN THE SUN, YOU WILL NOT TAN FROM USE OF THIS DEVICE.

1327 § 63.2-1716. Child day center operated by religious institution exempt from licensure; annual
1328 statement and documentary evidence required; enforcement; injunctive relief.

1329 A. Notwithstanding any other provisions of this chapter, a child day center, including a child day
1330 center that is a child welfare agency operated or conducted under the auspices of a religious institution
1331 shall be exempt from the licensure requirements of this subtitle, but shall comply with the provisions of
1332 this section unless it chooses to be licensed. If such religious institution chooses not to be licensed, it
1333 shall file with the Commissioner, prior to beginning operation of a child day center and thereafter
1334 annually, a statement of intent to operate a child day center, certification that the child day center has
1335 disclosed in writing to the parents or guardians of the children in the center the fact that it is exempt
1336 from licensure, the qualifications of the personnel employed therein and documentary evidence that:

1337 1. Such religious institution has tax exempt status as a nonprofit religious institution in accordance
1338 with § 501 (c) of the Internal Revenue Code of 1954, as amended, or that the real property owned and
1339 exclusively occupied by the religious institution is exempt from local taxation.

1340 2. Within the prior 90 days for the initial exemption and within the prior 180 days for exemptions
1341 thereafter, the local health department and local fire marshal or Office of the State Fire Marshal,
1342 whichever is appropriate, have inspected the physical facilities of the child day center and have
1343 determined that the center is in compliance with applicable laws and regulations with regard to food
1344 service activities, health and sanitation, water supply, building codes, and the Statewide Fire Prevention

Code or the Uniform Statewide Building Code.

3. The child day center employs supervisory personnel according to the following ratio of staff to children:

- a. One staff member to four children from zero to twenty-four months.
- b. One staff member to ten children from ages twenty-four months to six years.
- c. One staff member to twenty-five children ages six years and older.

Staff shall be counted in the required staff-to-children ratios only when they are directly supervising children. In each grouping of children, at least one adult staff member shall be regularly present. Staff members shall be at least 16 years of age. Staff members under 18 years of age shall be under the supervision of an adult staff member. Adult staff members shall supervise no more than two staff members under 18 years of age at any given time.

4. Each person in a supervisory position has been certified by a practicing physician *or physician assistant* to be free from any disability which would prevent him from caring for children under his supervision.

5. The center is in compliance with the requirements of:

- a. This section.
- b. Section 63.2-1724 relating to background checks.
- c. Section 63.2-1509 relating to the reporting of suspected cases of child abuse and neglect.
- d. Chapter 3 (§ 46.2-300 et seq.) of Title 46.2 regarding a valid Virginia driver's license or commercial driver's license; of Article 21 (§ 46.2-1157 et seq.) of Chapter 10 of Title 46.2, regarding vehicle inspections; ensuring that any vehicle used to transport children is an insured motor vehicle as defined in § 46.2-705; and Article 13 (§ 46.2-1095 et seq.) of Chapter 10 of Title 46.2, regarding child restraint devices.

6. The following aspects of the child day center's operations are described in a written statement provided to the parents or guardians of the children in the center and made available to the general public: physical facilities, enrollment capacity, food services, health requirements for the staff and public liability insurance.

B. The center shall establish and implement procedures for:

- 1. Hand washing by staff and children before eating and after toileting and diapering.
- 2. Appropriate supervision of all children in care, including daily intake and dismissal procedures to ensure safety of children.

3. A daily simple health screening and exclusion of sick children by a person trained to perform such screenings.

4. Ensuring that a person trained and certified in first aid is present at the center whenever children are present.

5. Ensuring that all children in the center are in compliance with the provisions of § 32.1-46 regarding the immunization of children against certain diseases.

6. Ensuring that all areas of the premises accessible to children are free of obvious injury hazards, including providing and maintaining sand or other cushioning material under playground equipment.

7. Ensuring that all staff are able to recognize the signs of child abuse and neglect.

C. The Commissioner may perform on-site inspections of religious institutions to confirm compliance with the provisions of this section and to investigate complaints that the religious institution is not in compliance with the provisions of this section. The Commissioner may revoke the exemption for any child day center in serious or persistent violation of the requirements of this section. If a religious institution operates a child day center and does not file the statement and documentary evidence required by this section, the Commissioner shall give reasonable notice to such religious institution of the nature of its noncompliance and may thereafter take such action as he determines appropriate, including a suit to enjoin the operation of the child day center.

D. Any person who has reason to believe that a child day center falling within the provisions of this section is not in compliance with the requirements of this section may report the same to the local department, the local health department or the local fire marshal, each of which may inspect the child day center for noncompliance, give reasonable notice to the religious institution, and thereafter may take appropriate action as provided by law, including a suit to enjoin the operation of the child day center.

E. Nothing in this section shall prohibit a child day center operated by or conducted under the auspices of a religious institution from obtaining a license pursuant to this chapter.

§ 63.2-1808. Rights and responsibilities of residents of assisted living facilities; certification of licensure.

A. Any resident of an assisted living facility has the rights and responsibilities enumerated in this section. The operator or administrator of an assisted living facility shall establish written policies and procedures to ensure that, at the minimum, each person who becomes a resident of the assisted living facility:

- 1406 1. Is fully informed, prior to or at the time of admission and during the resident's stay, of his rights
1407 and of all rules and expectations governing the resident's conduct, responsibilities, and the terms of the
1408 admission agreement; evidence of this shall be the resident's written acknowledgment of having been so
1409 informed, which shall be filed in his record;
- 1410 2. Is fully informed, prior to or at the time of admission and during the resident's stay, of services
1411 available in the facility and of any related charges; this shall be reflected by the resident's signature on a
1412 current resident's agreement retained in the resident's file;
- 1413 3. Unless a committee or conservator has been appointed, is free to manage his personal finances and
1414 funds regardless of source; is entitled to access to personal account statements reflecting financial
1415 transactions made on his behalf by the facility; and is given at least a quarterly accounting of financial
1416 transactions made on his behalf when a written delegation of responsibility to manage his financial
1417 affairs is made to the facility for any period of time in conformance with state law;
- 1418 4. Is afforded confidential treatment of his personal affairs and records and may approve or refuse
1419 their release to any individual outside the facility except as otherwise provided in law and except in case
1420 of his transfer to another care-giving facility;
- 1421 5. Is transferred or discharged only when provided with a statement of reasons, or for nonpayment
1422 for his stay, and is given reasonable advance notice; upon notice of discharge or upon giving reasonable
1423 advance notice of his desire to move, shall be afforded reasonable assistance to ensure an orderly
1424 transfer or discharge; such actions shall be documented in his record;
- 1425 6. In the event a medical condition should arise while he is residing in the facility, is afforded the
1426 opportunity to participate in the planning of his program of care and medical treatment at the facility
1427 and the right to refuse treatment;
- 1428 7. Is not required to perform services for the facility except as voluntarily contracted pursuant to a
1429 voluntary agreement for services that states the terms of consideration or remuneration and is
1430 documented in writing and retained in his record;
- 1431 8. Is free to select health care services from reasonably available resources;
- 1432 9. Is free to refuse to participate in human subject experimentation or to be party to research in
1433 which his identity may be ascertained;
- 1434 10. Is free from mental, emotional, physical, sexual, and economic abuse or exploitation; is free from
1435 forced isolation, threats or other degrading or demeaning acts against him; and his known needs are not
1436 neglected or ignored by personnel of the facility;
- 1437 11. Is treated with courtesy, respect, and consideration as a person of worth, sensitivity, and dignity;
- 1438 12. Is encouraged, and informed of appropriate means as necessary, throughout the period of stay to
1439 exercise his rights as a resident and as a citizen; to this end, he is free to voice grievances and
1440 recommend changes in policies and services, free of coercion, discrimination, threats or reprisal;
- 1441 13. Is permitted to retain and use his personal clothing and possessions as space permits unless to do
1442 so would infringe upon rights of other residents;
- 1443 14. Is encouraged to function at his highest mental, emotional, physical and social potential;
- 1444 15. Is free of physical or mechanical restraint except in the following situations and with appropriate
1445 safeguards:
- 1446 a. As necessary for the facility to respond to unmanageable behavior in an emergency situation,
1447 which threatens the immediate safety of the resident or others;
- 1448 b. As medically necessary, as authorized in writing by a physician, to provide physical support to a
1449 weakened resident;
- 1450 16. Is free of prescription drugs except where medically necessary, specifically prescribed, and
1451 supervised by the attending physician, *physician assistant*, or nurse practitioner;
- 1452 17. Is accorded respect for ordinary privacy in every aspect of daily living, including but not limited
1453 to the following:
- 1454 a. In the care of his personal needs except as assistance may be needed;
- 1455 b. In any medical examination or health-related consultations the resident may have at the facility;
- 1456 c. In communications, in writing or by telephone;
- 1457 d. During visitations with other persons;
- 1458 e. In the resident's room or portion thereof; residents shall be permitted to have guests or other
1459 residents in their rooms unless to do so would infringe upon the rights of other residents; staff may not
1460 enter a resident's room without making their presence known except in an emergency or in accordance
1461 with safety oversight requirements included in regulations of the Board;
- 1462 f. In visits with his spouse; if both are residents of the facility they are permitted but not required to
1463 share a room unless otherwise provided in the residents' agreements; and
- 1464 18. Is permitted to meet with and participate in activities of social, religious, and community groups
1465 at his discretion unless medically contraindicated as documented by his physician, *physician assistant*, or
1466 nurse practitioner in his medical record.
- 1467 B. If the resident is unable to fully understand and exercise the rights and responsibilities contained

in this section, the facility shall require that a responsible individual, of the resident's choice when possible, designated in writing in the resident's record, be made aware of each item in this section and the decisions that affect the resident or relate to specific items in this section; a resident shall be assumed capable of understanding and exercising these rights unless a physician determines otherwise and documents the reasons for such determination in the resident's record.

C. The rights and responsibilities of residents shall be printed in at least 12-point type and posted conspicuously in a public place in all assisted living facilities. The facility shall also post the name and telephone number of the regional licensing supervisor of the Department, the Adult Protective Services' toll-free telephone number, as well as the toll-free telephone number for the Virginia Long-Term Care Ombudsman Program, any sub-state ombudsman program serving the area, and the toll-free number of the Virginia Office for Protection and Advocacy.

D. The facility shall make its policies and procedures for implementing this section available and accessible to residents, relatives, agencies, and the general public.

E. The provisions of this section shall not be construed to restrict or abridge any right that any resident has under law.

F. Each facility shall provide appropriate staff training to implement each resident's rights included in this section.

G. The Board shall adopt regulations as necessary to carry out the full intent of this section.

H. It shall be the responsibility of the Commissioner to ensure that the provisions of this section are observed and implemented by assisted living facilities as a condition to the issuance, renewal, or continuation of the license required by this article.