19103239D

# SENATE BILL NO. 1361

Offered January 9, 2019

Prefiled January 8, 2019

*A BILL to amend and reenact §§ 15.2-5386, 23.1-2412, 32.1-122.05, 32.1-122.10:001, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-162.1, 32.1-276.5, 54.1-2400.6, and 56-484.19 of the Code of Virginia and to repeal Article 1.1 (§§ 32.1-102.1 through 32.1-102.11) of Chapter 4 of Title 32.1 of the Code of Virginia, relating to certificate of public need.*

Patron—Wagner

Referred to Committee on Education and Health

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 15.2-5386, 23.1-2412, 32.1-122.05, 32.1-122.10:001, 32.1-125.3, 32.1-126.1, 32.1-126.3, 32.1-162.1, 32.1-276.5, 54.1-2400.6, and 56-484.19 of the Code of Virginia are amended and reenacted as follows:**

**§ 15.2-5386. Limitations of the Authority.**

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

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

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

**§ 23.1-2412. Transfer of existing hospital facilities.**

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

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

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

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

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

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

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

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

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

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

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

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

1. The debt service accruing during the term of the lease on all outstanding bonds issued for the

purpose of financing the acquisition, construction, or improvement of the hospital facilities on which rent is paid; or

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

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

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

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

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

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

G. Funds held by or for the University or any of its predecessors or divisions, including funds held by the University Foundation or the MCV Foundation for the benefit of MCV Hospitals or any of its predecessors for use in operating, maintaining, or constructing hospital facilities, providing medical and health sciences education, or conducting medical or related research may be transferred, in whole or in part, to the Authority if the University or any foundation determines that the transfer is consistent with the intended use of the funds. The University may direct in writing that all or part of the money or property representing its beneficial interest under a will, trust agreement, or other donative instrument be distributed to the Authority if the University determines that such direction furthers any of the original purposes of the will, trust agreement, or other instrument. Such a direction shall not be considered a waiver, disclaimer, renunciation, assignment, or disposition of the beneficial interest by the University. A fiduciary's distribution to the Authority pursuant to such a written direction from the University is a distribution to the University for all purposes relating to the donative instrument, and the fiduciary has no liability for distributing any money or property to the Authority pursuant to such a direction. Nothing in this section shall deprive any court of its jurisdiction to determine whether such a distribution is appropriate under its cy pres powers or otherwise.

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

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

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

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

**§ 32.1-122.05. Regional health planning agencies; boards; duties and responsibilities.**

A. For the purpose of representing the interests of health planning regions and performing health planning activities at the regional level, there are hereby created such regional health planning agencies as may be designated by the Board of Health.

B. Each regional health planning agency shall be governed by a regional health planning board to be composed of not more than thirty residents of the region. The membership of the regional health planning boards shall include, but not be limited to, consumers, providers, a director of a local health department, a director of a local department of social services or welfare, a director of a community services board, a director of an area agency on aging and representatives of health care insurers, local governments, the business community and the academic community. The majority of the members of each regional health planning board shall be consumers. Consumer members shall be appointed in a manner that ensures the equitable geographic and demographic representation of the region. Provider members shall be solicited from professional organizations, service and educational institutions and associations of service providers and health care insurers in a manner that assures equitable representation of provider interest.

The members of the regional health planning boards shall be appointed for no more than two consecutive terms of four years or, when appointed to fill an unexpired term of less than four years, for three consecutive terms consisting of one term of less than four years and two terms of four years. The boards shall not be self-perpetuating. The Board of Health shall establish procedures requiring staggered terms. The composition and the method of appointment of the regional health planning boards shall be established in the regulations of the Board of Health. In addition, the Board of Health shall require, pursuant to regulations, each regional health planning board to report and maintain a record of its membership, including, but not limited to, the names, addresses, dates of appointment, years served, number of consecutive and nonconsecutive terms, and the group represented by each member. These membership reports and records shall be public information and shall be published in accordance with the regulations of the Board.

C. An agreement shall be executed between the Commissioner, in consultation with the Board of Health, and each regional health planning board to delineate the work plan and products to be developed with state funds. Funding for the regional health planning agencies shall be contingent upon meeting these obligations and complying with the Board's regulations.

D. Each regional health planning agency shall assist the Board of Health by: (i) conducting data collection, research and analyses as required by the Board; (ii) preparing reports and studies in consultation and cooperation with the Board; (iii) reviewing and commenting on the components of the State Health Plan; (iv) conducting needs assessments as appropriate and serving as a technical resource to the Board; (v) identifying gaps in services, inappropriate use of services or resources and assessing accessibility of critical services; *and* (vi) ~~reviewing applications for certificates of public need and making recommendations to the Department thereon as provided in § 32.1-102.6; and (vii)~~ conducting such other functions as directed by the regional health planning board. All regional health planning agencies shall demonstrate and document accountability for state funds through annual budget projections and quarterly expenditure and activity reports that shall be submitted to the Commissioner. A regional health planning agency may designate membership and activities at subarea levels as deemed appropriate by its regional health planning board. Each regional health planning board shall adopt bylaws for its operation and for the election of its chairman and shall maintain and publish a record of its membership and any subarea levels as required by this section and the regulations of the Board of Health.

**§ 32.1-122.10:001. Purpose; one or more localities may create authority; advertisement and notice of hearing.**

A. Communities lack the ability to coordinate, across jurisdictions, health partnership efforts between local governments and private providers of health care services, which leads to duplicative and inefficient services. Such public/private partnerships could (i) encourage the use of service delivery that otherwise might have required government funding or programs; (ii) allow governments to fully participate in such partnerships; (iii) maximize the willingness of individuals, agencies and private organizations to lend their expertise to help satisfy community needs; (iv) allow innovative funding mechanisms to leverage public funds; (v) allow appropriate information sharing to ensure the adequacy and quality of services delivered; (vi) provide liability protection for volunteers providing services under programs sponsored or approved by the authority; (vii) provide a mechanism to ensure that services provided in the community are necessary, appropriate, and provided by trained and supervised persons; and (viii) allow volunteers and others to focus their energies to achieve community health improvement. Health care services include, but are not limited to, treatment of and education about acute and chronic diseases, wellness and prevention activities that promote the health of communities, and access to services and activities.

B. The governing body of a locality may by ordinance or resolution, or the governing bodies of two

or more localities may by concurrent ordinances or resolutions or by agreement, create a local health partnership authority which shall have as its purpose developing partnerships between public and private providers. The ordinance, resolution or agreement creating the authority shall not be adopted or approved until a public hearing has been held on the question of its adoption or approval. The authority shall be a public body politic and corporate.

C. The governing body of each participating locality shall cause to be advertised at least one time in a newspaper of general circulation in such locality a copy of the ordinance, resolution or agreement creating the authority, or a descriptive summary of the ordinance, resolution or agreement and a reference to the place where a copy of such ordinance, resolution or agreement can be obtained, and notice of the day, not less than 30 days after publication of the advertisement, on which a public hearing will be held on the ordinance, resolution or agreement.

D. ~~No authority created pursuant to this article shall be exempt from any of the provisions of the Certificate of Public Need laws and regulations of the Commonwealth.~~

~~E.~~ No authority created pursuant to this article shall be allowed to issue bonds or other form of indebtedness.

~~F.~~ *E.* Any authority created pursuant to this article shall report on programmatic initiatives on an annual basis to the Joint Commission on Health Care.

**§ 32.1-125.3. Bed capacity and licensure in hospitals designated as critical access hospitals; designation as rural hospital.**

~~A. Any medical care facility licensed as a hospital pursuant to this article that (i) has been certified, as provided in § 32.1-122.07, as a critical access hospital by the Commissioner of Health in compliance with the certification regulations promulgated by the Health Care Financing Administration pursuant to Title XVIII of the Social Security Act, as amended, and (ii) has, as a result of the critical access certification, been required to reduce its licensed bed capacity to conform to the critical access certification requirement shall, upon termination of its critical access hospital certification, be licensed to operate at the licensed bed capacity in existence prior to the critical access hospital certification without being required to apply for and obtain a certificate of public need for such bed capacity in accordance with Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title.~~

~~B.~~ Any medical care facility licensed as a hospital shall be considered a rural hospital on and after September 30, 2004, pursuant to 42 U.S.C. § 1395ww (d)(8)(E)(ii)(II), if (i) the hospital is located in an area defined as rural by federal statute or regulation; (ii) the Board of Health defines, in regulation, the area in which the hospital is located as a rural health area or the hospital as a rural hospital; or (iii) the hospital was designated, prior to October 1, 2004, as a Medicare-dependent small rural health hospital, as defined in 42 U.S.C. § 1395ww (d)(5)(G)(iv).

**§ 32.1-126.1. Asbestos inspection for hospitals.**

The Commissioner shall not issue a license to or renew the license of any hospital which is located in a building built prior to 1978 until he receives a written statement that either (i) the hospital has been inspected for asbestos in accordance with standards in effect at the time of inspection; or (ii) that asbestos inspection will be conducted within twelve months of issuance or renewal, in accordance with the standards established pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all other buildings; and (iii) that response actions have been or will be undertaken in accordance with applicable standards. Any asbestos management program or response action undertaken by a hospital shall comply with the standards promulgated pursuant to § 2.2-1164 in the case of state-owned buildings or § 36-99.7 in the case of all others.

The Commissioner may amend the standards for inspections, management programs and response actions for hospitals subject to this section, in accordance with the requirements of the Virginia Administrative Process Act (§ 2.2-4000 et seq.).

~~The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures made by hospitals pursuant to the provisions of this section.~~

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

After January 1, 1998, the Commissioner shall not issue a license to or renew the license of any hospital, regardless of when such facility was constructed, unless the hospital is equipped with an automatic sprinkler system which complies with the regulations of the Board of Housing and Community Development.

The Commissioner may, at his discretion, extend the time for compliance with this section for any hospital that can demonstrate (i) its inability to comply, if such hospital submits, prior to January 1, 1998, a plan for compliance by a date certain which shall be no later than July 1, 1998, or (ii) that construction is underway for a new facility to house the services currently located in the noncomplying facility and that such construction will be completed and the noncomplying facility relocated by December 31, 1998.

~~The provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall not apply to expenditures required solely for compliance with this section.~~

For the purposes of this section and § 36-99.9:1, "automatic sprinkler system" means a device for suppressing fire in patient rooms and other areas of the hospital customarily used for patient care.

**§ 32.1-162.1. Definitions.**

As used in this article, unless a different meaning or construction is clearly required by the context or otherwise:

"Hospice" means a coordinated program of home and inpatient care provided directly or through an agreement under the direction of an identifiable hospice administration providing palliative and supportive medical and other health services to terminally ill patients and their families. A hospice utilizes a medically directed interdisciplinary team. A hospice program of care provides care to meet the physical, psychological, social, spiritual and other special needs which are experienced during the final stages of illness, and during dying and bereavement. Hospice care shall be available twenty-four hours a day, seven days a week.

"Hospice facility" means an institution, place, or building owned or operated by a hospice provider and licensed by the Department to provide room, board, and appropriate hospice care on a 24-hour basis, including respite and symptom management, to individuals requiring such care pursuant to the orders of a physician. ~~Such facilities with 16 or fewer beds are exempt from Certificate of Public Need laws and regulations. Such facilities with more than 16 beds shall be licensed as a nursing facility or hospital and shall be subject to Certificate of Public Need laws and regulations.~~

"Hospice patient" means a diagnosed terminally ill patient, with an anticipated life expectancy of six months or less, who, alone or in conjunction with designated family members, has voluntarily requested admission and been accepted into a licensed hospice program.

"Hospice patient's family" shall mean the hospice patient's immediate kin, including a spouse, brother, sister, child or parent. Other relations and individuals with significant personal ties to the hospice patient may be designated as members of the hospice patient's family by mutual agreement among the hospice patient, the relation or individual, and the hospice team.

"Identifiable hospice administration" means an administrative group, individual or legal entity that has a distinct organizational structure, accountable to the governing authority directly or through a chief executive officer. This administration shall be responsible for the management of all aspects of the program.

"Inpatient" means the provision of services, such as food, laundry, housekeeping, and staff to provide health or health-related services, including respite and symptom management, to hospice patients, whether in a hospital, nursing facility, or hospice facility.

"Interdisciplinary team" means the patient and the patient's family, the attending physician, and the following hospice personnel: physician, nurse, social worker, and trained volunteer. Providers of special services, such as clergy, mental health, pharmacy, and any other appropriate allied health services may also be included on the team as the needs of the patient dictate.

"Palliative care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient and family as they experience the stress of the dying process, rather than the treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

**§ 32.1-276.5. Providers to submit data; civil penalty.**

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section. Such data shall include relevant data and information for any parent or subsidiary company of the health care provider that operates in the Commonwealth. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

B. In addition, health maintenance organizations shall annually submit to the Commissioner, to make available to consumers who make health benefit enrollment decisions, audited data consistent with the latest version of the Health Employer Data and Information Set (HEDIS), as required by the National Committee for Quality Assurance, or any other quality of care or performance information set as approved by the Board. The Commissioner, at his discretion, may grant a waiver of the HEDIS or other approved quality of care or performance information set upon a determination by the Commissioner that the health maintenance organization has met Board-approved exemption criteria. The Board shall promulgate regulations to implement the provisions of this section.

The Commissioner shall also negotiate and contract with a nonprofit organization authorized under § 32.1-276.4 for compiling, storing, and making available to consumers the data submitted by health maintenance organizations pursuant to this section. The nonprofit organization shall assist the Board in developing a quality of care or performance information set for such health maintenance organizations and shall, at the Commissioner's discretion, periodically review this information set for its effectiveness.

C. ~~Every medical care facility as that term is defined in § 32.1-102.1 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the~~

~~Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.~~

~~Every medical care facility for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report to the Commissioner data on charity care, as that term is defined in § 32.1-102.1, provided to satisfy a condition of a certificate of public need, including (i) the total amount of such charity care the facility provided to indigent persons; (ii) the number of patients to whom such charity care was provided; (iii) the specific services delivered to patients that are reported as charity care recipients; and (iv) the portion of the total amount of such charity care provided that each service represents. The value of charity care reported shall be based on the medical care facility's submission of applicable Diagnosis Related Group codes and Current Procedural Terminology codes aligned with methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. Notwithstanding the foregoing, every nursing home as defined in § 32.1-123 for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report data on utilization and other data in accordance with regulations of the Board.~~

~~A medical care facility that fails to report data required by this subsection shall be subject to a civil penalty of up to $100 per day per violation, which shall be collected by the Commissioner and paid into the Literary Fund.~~

~~D.~~ Every continuing care retirement community established pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 that includes nursing home beds shall report data on utilization of such nursing home beds to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data.

~~E.~~ *D.* Every hospital that receives a disproportionate share hospital adjustment pursuant to § 1886(d)(5)(F) of the Social Security Act shall report, in accordance with regulations of the Board consistent with recommendations of the nonprofit organization in its strategic plan submitted and provided pursuant to § 32.1-276.4, the number of inpatient days attributed to patients eligible for Medicaid but not Medicare Part A and the total amount of the disproportionate share hospital adjustment received.

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

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

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

1. Any information of which he may become aware in his official capacity indicating that such a health professional is in need of treatment or has been committed or admitted as a patient, either at his institution or any other health care institution, for treatment of substance abuse or a psychiatric illness that may render the health professional a danger to himself, the public or his patients.

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

3. Any disciplinary proceeding begun by the institution, organization, facility, or provider as a result of conduct involving (i) intentional or negligent conduct that causes or is likely to cause injury to a patient or patients, (ii) professional ethics, (iii) professional incompetence, (iv) moral turpitude, or (v)

substance abuse. The report required under this subdivision shall be submitted within 30 days of the date of written communication to the health professional notifying him of the initiation of a disciplinary proceeding.

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

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

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

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

B. Any report required by this section concerning the commitment or admission of such health professional as a patient shall be made within five days of when the chief executive officer, chief of staff, director, or administrator learns of such commitment or admission.

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

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

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

F. Any person who fails to make a report to the Department as required by this section shall be subject to a civil penalty not to exceed $25,000 assessed by the Director. The Director shall report the

assessment of such civil penalty to the Commissioner of Health, Commissioner of Social Services, or Commissioner of Behavioral Health and Developmental Services, as appropriate. Any person assessed a civil penalty pursuant to this section shall not receive a license or certification or renewal of such unless such penalty has been paid pursuant to § 32.1-125.01. The Medical College of Virginia Hospitals and the University of Virginia Hospitals shall not receive certification pursuant to § 32.1-137 ~~or Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1~~ unless such penalty has been paid.

**§ 56-484.19. Definitions.**

As used in this article:

"Alternative method of providing call location information" means a method of maintaining and operating a multiline telephone system that ensures that:

1. Emergency calls from a telephone station provide the PSAP with sufficient location identification information to ensure that emergency responders are dispatched to a location at the facility from which the emergency call was placed, from which location emergency responders will be able to ascertain the telephone station where the emergency call was placed (i) by being able to view all of the telephone stations in the area contiguous to the telephone station from which the emergency call was placed or (ii) by the activation of an alerting system at the facility, which activation is triggered by the placing of the emergency call, and which readily allows arriving emergency responders to determine the physical location of the telephone station from which the emergency call was placed. A light or alarm located near the telephone station is an example of such an alerting system;

2. Emergency calls from a telephone station, in addition to reaching a PSAP, connect to or otherwise notify a switchboard operator, attendant, or other designated on-site individual who is capable of giving the PSAP the location of the telephone station from which the emergency call was placed; or

3. Calls to the digits "9-1-1" from a telephone station connect to a private emergency answering point.

An alternative method of providing call location information shall also be deemed to be provided, as a result of the imputed ability of emergency responders to readily locate all telephone stations from which the emergency call could have been placed, when emergency calls provide calling party information corresponding to a contiguous area containing the telephone from which the emergency call was placed, of fewer than 7,000 square feet, located on one or more floors.

"Automatic location identification" or "ALI" means the automatic display at a PSAP of information defining the emergency call location, which information shall identify the floor name or number, room name or number, building name or number, cubicle name or number, and office name or number, as applicable, or imparts other information that is sufficiently specific to provide the emergency responders with the ability to locate the telephone station from which the emergency call was placed.

"Automatic number identification" or "ANI" means the automatic display at a PSAP of a telephone number that a PSAP may use to call the telephone station from which the emergency call was placed.

"Calling party information" means information that is delivered by the MLTS provider to the PSAP that is used to provide the ANI and ALI function.

"Central office system" means a business telephone service offered by a provider of communications services that provides features similar to a private branch exchange by transmitting data over telecommunications equipment or cable lines.

"Emergency call" means a telephone call that enables the user to reach a PSAP by dialing the digits "9-1-1" and, if applicable, any additional digit or digits that must be dialed in order to permit the user to access the public switched telephone network.

"Emergency call location" means the location of the telephone station on an MLTS from which an emergency call is placed and to which a PSAP may dispatch emergency responders based upon ALI provided via the emergency call.

"Emergency responders" means fire services, law enforcement, emergency medical services, and other public services or agencies that may be dispatched by a PSAP in response to an emergency call.

"Enhanced 9-1-1 service" means a service consisting of telephone network features and PSAPs that (i) enables users of telephone systems to reach a PSAP by making an emergency call; (ii) automatically directs emergency calls to the appropriate PSAPs by selective routing based on the geographical location from which the emergency call originated; and (iii) provides the capability for ANI and ALI features.

"Facility" means real estate and improvements used principally for or as a (i) hotel as defined in § 35.1-1, (ii) dormitory at an institution of higher education, (iii) medical care facility ~~as defined in § 32.1-102.1~~, (iv) group home or other residential facility licensed by the Department of Behavioral Health and Developmental Services or Department of Social Services, (v) assisted living facility as defined in § 63.2-100, (vi) apartment complex or condominium where shared tenant telephone service is provided, (vii) commercial or government office building, (viii) manufacturing, processing, assembly, warehouse, or distribution establishment, or (ix) retail establishment.

*"Medical care facility" means any institution, place, building, or agency, whether or not licensed or required to be licensed by the Board or the Department of Behavioral Health and Developmental*

*Services, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated, or offered for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition, whether medical or surgical, of two or more nonrelated persons who are injured or physically sick or have mental illness, or for the care of two or more nonrelated persons requiring or receiving medical, surgical, or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled or (ii) that is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. "Medical care facility" does not include any facility of (a) the Department of Behavioral Health and Developmental Services; (b) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Behavioral Health and Developmental Services' Comprehensive State Plan; (c) an intermediate care facility for individuals with intellectual disability (ICF/IID) that has no more than 12 beds and is in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services; (d) a physician's office, except that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, or nuclear medicine imaging, except for the purpose of nuclear cardiac imaging; (e) the Wilson Workforce and Rehabilitation Center of the Department for Aging and Rehabilitative Services; (f) the Department of Corrections; or (g) the Department of Veterans Services. "Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.*

"MLTS provider" means a person who operates a facility at which telephone service is provided, with or without compensation, through a multiline telephone system.

"MLTS service provider" means a person offering or operating third party services that combine communications services, private branch exchange or central office systems, and multiline telephone systems where such services are provided to an MLTS provider on a fee-for-service basis.

"Multiline telephone system" or "MLTS" means a telephone system, including network-based or premises-based systems, whether owned or leased by a public or private entity, operated in the Commonwealth, that serves a facility, has more than one telephone station, and is comprised of common control units, telephones, and control hardware and software that share a common interface to the public switched telephone network, whether by a private branch exchange or central office system, without regard to whether the system utilizes VoIP technology.

"Person" includes any individual, corporation, partnership, association, cooperative, limited liability company, trust, joint venture, government, political subdivision, or any other legal or commercial entity and any successor, representative, agent, agency, or instrumentality thereof.

"Portable VoIP services" includes any MLTS utilizing a VoIP service and providing an end user with the capability to use the service at a location independent of the original physical location of telephone stations on the MLTS.

"Private emergency answering point" means an answering point that is equipped and staffed during all hours that the facility is occupied to provide adequate means of responding to calls to the digits "9-1-1" from telephones on a multiline telephone system by reporting incidents to a PSAP in a manner that identifies the emergency response location from which the call to the answering point was placed.

"Public safety answering point" or "PSAP" means a communications operation operated by or on behalf of a governmental entity that is equipped and staffed on a 24-hour basis to receive and process telephone calls for emergency assistance from an individual by dialing, in addition to any digits required to obtain an outside line, the digits "9-1-1."

"Public switched telephone network" means the worldwide, interconnected networks of equipment, lines, and controls assembled to establish circuit-switched voice communication paths between calling and called parties.

"Retail establishment" means any establishment selling goods or services to the ultimate user or consumer of those goods or services, not for the purpose of resale, but for that user's or consumer's personal rather than business use.

"Telephone call" means the use of a telephone to initiate an ordinary voice transmission placed through the public switched telephone network.

"Telephone station" means a telephone on a multiline telephone system, from which a call may be placed to a PSAP by dialing, in addition to any digits required to access the public switched telephone network, the digits "9-1-1." However, in any medical care facility or licensed assisted living facility, "telephone station" includes any telephone on a multiline telephone system located in an administrative office, nursing station, lobby, waiting area, or other area accessible to the general public but does not

include a telephone located in the room of a patient or resident.

"VoIP service" has the same meaning ascribed to it in § 56-484.12.

**2. That Article 1.1 (§§ 32.1-102.1 through 32.1-102.11) of Chapter 4 of Title 32.1 of the Code of Virginia is repealed.**