

2004 ANNUAL REPORT OF

The Joint Commission on Health Care

**TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA**



REPORT DOCUMENT NO. 79

**COMMONWEALTH OF VIRGINIA
RICHMOND
2005**



COMMONWEALTH of VIRGINIA
Joint Commission on Health Care

Delegate Harvey B. Morgan
Chairman
Kim Snead
Executive Director

April 19, 2005

900 E. Main Street, Suite 3072E
P.O. Box 1322
Richmond, Virginia 23218
(804) 786-5445
Fax (804) 786-5538

TO: The Honorable Mark R. Warner, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the *Code of Virginia* (Title 30, Chapter 18, §§30-168 through 30-170) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2004.

This 2004 Annual Report includes a summary of the Joint Commission's 2004 activities and legislative recommendations to the 2005 Session of the General Assembly and executive summaries of the studies that were completed. The final reports of the completed studies were published or made available on the General Assembly website. These reports are also available from the Joint Commission staff office.

Sincerely,

A handwritten signature in black ink, appearing to read "H. B. Morgan".

Harvey B. Morgan
Chairman

A handwritten signature in black ink, appearing to read "Kim Snead".

Kim Snead
Executive Director

JOINT COMMISSION ON HEALTH CARE: 2004

Chairman

The Honorable Harvey B. Morgan

Vice Chairman

The Honorable William C. Mims

The Honorable Harry B. Blevins
The Honorable R. Edward Houck
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Linda T. Puller
The Honorable Nick Rerras
The Honorable William C. Wampler, Jr.
The Honorable Clifford L. Athey, Jr.
The Honorable Robert H. Brink
The Honorable Benjamin L. Cline
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable R. Steven Landes
The Honorable Kenneth R. Melvin
The Honorable John M. O'Bannon, III
The Honorable John J. Welch, III

Secretary of Health and Human Resources

The Honorable Jane H. Woods

Executive Director

Kim Snead



JOINT COMMISSION ON HEALTH CARE

Executive Director
Kim Snead

Senior Health Policy Analyst
April R. Kees

Health Policy Analyst
Catherine W. Harrison

Intern
A. Ridgely Minter

Office Manager
Mamie V. White

The Joint Commission's home page on the Internet is located at:
<http://legis.state.va.us/jhc/jchchome.htm>

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 2004.



Table of Contents

- I. Summary of 2004 Activities and Related 2005
General Assembly Actions.....1
- II. Executive Summaries of 2004 JCHC Reports15

Appendix A: 2005 Legislation

I. SUMMARY OF 2004 ACTIVITIES AND RELATED 2005 GENERAL ASSEMBLY ACTIONS

STATUTORY AUTHORITY

The Joint Commission on Health Care (JCHC) was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032 to continue the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session). On July 1, 2003, the responsibilities of the Joint Commission on Behavioral Health Care were assumed by JCHC.

The Joint Commission is authorized in Title 30, Chapter 18, §30.168 through §30.170 of the *Code of Virginia*. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission endeavors to ensure that the greatest number of Virginians receives quality health care.

2004 JOINT COMMISSION ACTIVITIES

In keeping with its statutory mandate, the Joint Commission completed studies; considered the comments of advocates, industry representatives, and other interested parties; and introduced legislation to advance the quality of health care, long-term care and behavioral health care in the Commonwealth.

Five meetings of the Joint Commission were held; including a meeting in January 2005 before the 2005 General Assembly Session convened. The agenda for each meeting is shown on the following pages.

Agenda for May 4, 2004

- I. Call to Order
Delegate Harvey B. Morgan, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Status of Legislation and Proposed Workplan for 2004
Kim Snead
- IV. Review of Prescriptive Authority of Physician Assistants
April Kees, Senior Health Policy Analyst
- V. Review of Virginia's Newborn Screening Program
Kim Snead

Agenda for September 1, 2004

- I. Call to Order
Delegate Harvey B. Morgan, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- ~~III. Election of Officers~~
- IV. Activities of the Office of the Managed Care Ombudsman
Thomas S. Bridenstine, Managed Care Ombudsman, State Corporation Commission
- V. Update on Family Access to Medical Insurance Security
Linda L. Nablo, Director of the Division of Child Health Insurance
Department of Medical Assistance Services
- VI. Medicaid Reimbursement for Physicians
April Kees, Senior Health Policy Analyst
- VII. Healthy Lives Prescription Assistance Plan
Catherine Harrison, Health Policy Analyst
- VIII. Workplan for Study of Mental Health Needs and Treatment of
Young Minority Adults
Kim Snead

Agenda for October 26, 2004

- I. Call to Order
Delegate Harvey B. Morgan, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Report on Virginia Health Information
Richardson Grinnan, M.D., VHI Board of Directors
- IV. Disclosure of Health Records (HJR 134)
Patrick C. Devine, Jr., Esquire HIPAA Study Workgroup Chairman
- V. Benefits of Public-Private Partnerships to Medicaid Recipients (SJR 58)
Catherine W. Harrison, Health Policy Analyst
- VI. Issues Affecting Women's Obstetrical and Gynecological Health (HJR 144)
Jeffrey Lake, VDH Deputy Commissioner for Community Health Services
April Kees, Senior Health Policy Analyst JCHC
- VII. Review of Virginia's Newborn Screening Program, Final Report (HJR 164)
Kim Snead

Agenda for November 15, 2004

- I. Call to Order
Delegate Harvey B. Morgan, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Decision Matrix/Summary of Comments

Agenda for January 11, 2005

- I. Call to Order
Delegate Harvey B. Morgan, Chairman
- II. Discussion of Changes in Proposed Legislation
Kim Snead, Executive Director
- III. Identification of Patrons for Legislation and Budget Amendments
Delegate Harvey B. Morgan

SUBCOMMITTEE ACTIVITIES

The Joint Commission on Health Care has established two standing subcommittees—the Long-Term Care Subcommittee and the Behavioral Health Care Subcommittee.

Long-Term Care Subcommittee

The Long-Term Care Subcommittee, originally established in 1997, continued during 2004 with Delegate Hamilton as the Chairman.

Long-Term Care Subcommittee

Delegate Phillip A. Hamilton, Chairman

Delegate Robert H. Brink

Delegate Benjamin L. Cline

Delegate Franklin P. Hall

Delegate R. Steven Landes

Delegate John M. O'Bannon, III

Delegate John J. Welch, III

Delegate Harvey B. Morgan (ex-officio)

Senator Harry B. Blevins

Senator R. Edward Houck

Senator Benjamin J. Lambert, III

Senator Stephen H. Martin

Senator Linda T. Puller

The Long-Term Care Subcommittee held five meetings in 2004. The meeting agendas included the following reports:

Long-Term Care Subcommittee Agenda for June 29, 2004

- I. Call to Order
Delegate Phillip A. Hamilton, Chairman
- II. Overview of Agenda
April Kees, Senior Health Policy Analyst
- III. Presentations Regarding Assisted Living Facilities
Maurice A. Jones, Commissioner, Department of Social Services
Cindi B. Jones, Chief Deputy Director, Dept. of Medical Assistance Services
Joani F. Latimer, State Ombudsman, Office of the State LTC Ombudsman
Carter Harrison, State Public Policy Coordinator, Alzheimer's Association
George Braunstein representing VA Association of Community Services Boards, Inc.
David Sadowski, President, Virginia Coalition for the Aging
Beverley Soble, Vice President Regulatory Affairs, VA Health Care Association
Grant Goldman, Past President, Virginia Adult Home Association
Dana Steger, Legislative Affairs Legal Counsel, VA Association of Nonprofit Homes for the Aging
Kathy Selz, Associate Director, Virginia Assisted Living Association
- IV. Overview of 2004 LTC Studies and Proposed Subcommittee Workplan
April Kees

Long-Term Care Subcommittee Agenda for August 4, 2004

- I. Call to Order
Delegate Phillip A. Hamilton, Chairman
- II. Overview of Agenda
April Kees, Senior Health Policy Analyst
- III. Overview of Staffing Standards for Nursing Facilities
April Kees
- IV. Strategic Plan and Recommendations for Ensuring an Adequate
Supply of Nurses in Virginia (HB 2818, 2003)
Dr. Kimberly Waid, Associate for Academic Affairs
- V. Review of Long-Term Care Insurance Incentives
April Kees
- VI. Overview of Health Savings Accounts
April Kees
- VII. Workplan to Study the Access to and the Availability of Geriatricians
April Kees

Long-Term Care Subcommittee Agenda for September 1, 2004

- I. Call to Order
Delegate Phillip A. Hamilton, Chairman
- II. Overview of Agenda and Public Comments on NF Staffing Standards
April Kees, Senior Health Policy Analyst
- III. Report on Health Savings Accounts
Mary P. Habel, Director of Office of State and Local Health Benefit Programs
Department of Human Resource Management
- IV. Information Regarding Health Savings Account Providers in Virginia
April Kees
- V. Report on an Assisted Living Facility/ Community Service Board Model
Mary Ann Bergeron, Executive Director
VA Association of Community Services Boards
- VI. Update on Increased Cost of Nursing Facility Liability Insurance
April Kees
- VII. Medicaid Reimbursement of Nursing Facility Liability Insurance Cost
Scott Crawford, Director of Provider Reimbursement Division
Department of Medical Assistance Services
- VIII. Report on Olmstead Plan JCHC Recommendations
April Kees

Long-Term Care Subcommittee Agenda for November 4, 2004

- I. Call to Order
Delegate Phillip A. Hamilton, Chairman
- II. Overview of Agenda
April Kees, Senior Health Policy Analyst
- III. Report on Proposed Assisted Living Changes
Jay W. DeBoer, Commissioner of Virginia Department for the Aging
- IV. Overview of Proposed Alzheimer's Disease/Dementia Assisted Living Waiver
N. Diana Thorpe, Director of Division of Long-Term Care Facilities
Department of Medical Assistance Services
- V. Review of Pain Management in Nursing Facilities
April Kees

Long-Term Care Subcommittee Agenda for November 15, 2004

- I. Call to Order
Delegate Phillip A. Hamilton, Chairman
- II. Overview of Agenda
April Kees, Senior Health Policy Analyst
- III. Decision Matrix/Summary of Comments
April Kees

Behavioral Health Care Subcommittee

The Behavioral Health Care Subcommittee was established in July 2003 with Senator Martin as Chairman.

Behavioral Health Care Subcommittee

Senator Stephen H. Martin, Chairman

Senator Harry B. Blevins

Senator R. Edward Houck

Senator William C. Mims

Senator Linda T. Puller

Senator William C. Wampler, Jr.

Delegate Robert H. Brink

Delegate Franklin P. Hall

Delegate R. Steven Landes

Delegate John M. O'Bannon, III

Delegate Harvey B. Morgan (ex officio)

The Behavioral Health Care Subcommittee held four meetings during 2004. The meeting agendas included the following reports:

Behavioral Health Care Subcommittee Agenda for June 29, 2004

- I. Call to Order
Senator Stephen H. Martin, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Proposed 2004 Workplan
Kim Snead

Behavioral Health Care Subcommittee Agenda for August 4, 2004

- I. Call to Order
Senator Stephen H. Martin, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Update on the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
James S. Reinhard, M.D., Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services
- IV. Forensic Workgroup Initiatives
James S. Reinhard, M.D.

Henrico County Jails: MH & SA Services
Sheriff Michael Wade and Dr. Louis Fox, Psy.D.

New River Valley Crisis Intervention Team
Victoria Huber Cochran, J.D.

Community Corrections Dual Treatment Track: Day Reporting Center Model
Scott VanBenschoten, MSW, Asst. Director
Chesterfield Cty Community Corrections Services
- V. Report on Activities of the Office of the Inspector General
James W. Stewart, III, Inspector General
- VI. Status Report on the Implementation of Medicaid Preferred Drug List
Patrick W. Finnerty, Director of Department of Medical Assistance Services
- VII. New Levels of Children's Community Residential Treatment Reimbursement by Medicaid
Catherine K. Hancock, MH Policy Analyst
Department of Medical Assistance Services

Behavioral Health Care Subcommittee Agenda for October 26, 2004

- I. Call to Order
Senator Stephen H. Martin, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Suicide Prevention across the Lifespan
David Suttle, M.D., Office of Family Health Services of VA Dept. of Health
- IV. Need for Guardians for Mentally Disabled Individuals
Debbie Burcham, Director of Mental Retardation Services
Henrico Area Mental Health and Retardation Board
- V. Department of Mental Health, Mental Retardation and
Substance Abuse Services Presentations

Reinvestment and Restructuring Initiatives
James S. Reinhard, M.D., Commissioner
Department of Mental Health, Mental Retardation and Substance Abuse Services

Initiatives Related to Treatment of Juveniles
Raymond R. Ratke, Deputy Commissioner

Initiatives Related to Treatment of Adult Offenders
James J. Morris, Ph.D., Director of Forensic Services

Inclusion of Cross-Training Issues in Law Enforcement Training
James M. Martinez, Jr., Director of Mental Health Services
- VI. Staff Report on Web-Based Reporting of Acute Psychiatric Beds
and Payment Rates for MR Waiver
Kim Snead

Behavioral Health Care Subcommittee Agenda for November 15, 2004

- I. Call to Order
Senator Stephen H. Martin, Chairman
- II. Overview of Agenda
Kim Snead, Executive Director
- III. Decision Matrix/Summary of Comments

JOINT COMMISSION ON HEALTH CARE FINAL REPORTS

During 2004, the Joint Commission conducted studies in response to six legislative requests. The findings of the studies were presented to the Commission during its 2004 meetings. The study presentations and staff reports were posted on the Joint Commission's Internet home page to allow interested individuals to download the documents for review and comment.

Public comments were solicited on all of the staff reports, and summaries of the comments were presented to the Joint Commission members. Following the public comment period, all of the reports were posted on the "Reports to the General Assembly" website section of the Legislative Information System.

The Joint Commission's 2004 studies are shown below:

Joint Commission on Health Care Reports to the General Assembly 2004

<u>Name of Study</u>	<u>Authority for Study</u>	<u>Document Number</u>
Disclosure of Health Records	HJR 134 (2004)	HD 27, 2005
Newborn Screening in Virginia	HJR 164 (2004)	HD 28, 2005
Prescriptive Authority of Physician Assistants	HB 2318 (2001)	HD 29, 2005
Mental Health Needs and Treatment of Young Minority Adults	SJR 25 (2004)	SD 12, 2005
Benefits of Public-Private Partnerships to Medicaid Recipients	SJR 58 (2004)	SD 13, 2005
Healthy Lives Prescription Assistance Program	HB 2225 and SB 1341 (2003)	RD 17, 2005

Notes:

Except as noted, joint resolutions and bills are from the 2004 General Assembly Session. JCHC reports are published as House/Senate or Report documents. These documents may be accessed from the General Assembly Homepage under Legislative Studies: Reports to the General Assembly or requested from the Bill Room in the General Assembly Building.

2005 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 2004, a package of legislative proposals (legislation and budget amendments) was introduced during the 2005 Session of the General Assembly.

Bills and Resolutions

The following paragraphs identify each bill or resolution as introduced. A copy of each approved bill or resolution is provided in Appendix A.

- HB 1492/
SB 1097** **Health Savings Accounts.**
Amend and reenact §§ 38.2-5601 and 38.2-5602 of the Code of Virginia, to amend the Code of Virginia by adding a section numbered 38.2-5602.1, and to repeal §§ 38.2-5600 and 38.2-5603 of the Code of Virginia, relating to the Virginia Health Savings Account Act. Both bills were approved and appear as *2005 Acts of Assembly* Chapters 572 and 503 respectively.
- HB 2363/
SB 1064** **Health Records Privacy**
Amend and reenact the § 32.1-127.1:03 of the *Code of Virginia* relating to health records privacy. Both bills were approved and appear as *2005 Acts of Assembly* Chapters 101 and 39 respectively.
- HB 2511/
SB 1184** **Newborn Screening**
Amend Title 32.1 to expand Virginia's panel for newborn screening to include additional disorders. HB 2511 was incorporated into HB 1824 (which was approved by the General Assembly and signed by the Governor). SB 1184 was approved and appears as *2005 Acts of Assembly* Chapter 717.
- HB 2512/
SB 1187** **Omnibus Bill regarding assisted living facilities.**
Requires administrators of assisted living facilities to be licensed by the Board of Long-Term Care Administrators within the Department of Health Professions (effective July 1, 2007). In addition, the bill permits the Commissioner to issue an order of summary suspension of a license to operate an assisted living facility in cases of immediate and substantial threat to the health, safety, and welfare of residents or participants. The bill increases the maximum civil penalties for assisted living facilities from \$500 to \$10,000 per inspection and directs that the civil penalties be placed in the newly created Assisted Living Facility Education and Technical Assistance Fund to fund staff training and technical assistance for assisted living facilities. HB 2512 was approved and appears as *2005 Acts of Assembly* Chapter 924. SB 1187 was incorporated into SB 1183 (which was approved by the General Assembly and signed by the Governor).

- HB 2513/
SB 1041** **Employer provided long-term care insurance tax credit.**
Grants an income tax credit to business taxpayers that provide long-term insurance for employees. The annual credit allowed is 10 percent of the costs of the long-term care insurance premiums but no more than (i) a total of \$5,000 or (ii) \$100 per employee, whichever is less. Both bills were left in the Senate Finance Committee.
- HB 2514/
SB 1110** **Disclosure of patient information by certain health care providers.**
Repeals provisions governing disclosure of patient information to third party payors by mental health, mental retardation, and substance abuse professionals. This bill is a recommendation of the Joint Commission on Health Care. Both bills were approved and appear as *2005 Acts of Assembly* Chapters 111 and 43 respectively.
- HB 2515/
SB 1203** **Copying Charges for Medical Records**
Amend and reenact §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the *Code of Virginia* regarding copying charges for medical records. Both bills were approved and appear as *2005 Acts of Assembly* Chapters 642 and 697.
- HB 2516/
SB 1109** **Minors' Records**
Amend and reenact the §§ 16.1-338, 54.1-2969, 20-124.6, and 2.2-3705.5 of the *Code of Virginia* relating to health records privacy related to minors' records. Both bills were approved and appear as *2005 Acts of Assembly* Chapters 181 and 227 respectively.

Resolutions

- HJR 701** **"Wrap-around" Medicare prescription drug coverage.**
Encourages the Commissioner of the Department for the Aging and the Commissioner of Health to include specifics on wrap-around coverage provided to the public in their Medicare prescription drug information. HJR 701 was adopted by the General Assembly.
- HJR 702/
SJR 363** **Feasibility of information distribution by Mission of Mercy.**
Encourages the departments for the Aging, Medical Assistance Services, and Health to work with the Virginia Dental Association and the Virginia Health Care Foundation on using the Mission of Mercy program to disseminate information on prescription assistance programs and Medicare prescription drug discount cards. Both resolutions were adopted by the General Assembly.

Budget Amendment Requests

Nineteen budget amendments were introduced on behalf of JCHC during the 2005 General Assembly Session. The actions taken on the budget amendments are shown on the next two pages.

2005 JCHC Budget Amendments Included in the Approved Budget

Language directing DMAS to report to JCHC on the Healthy Returns Disease Management Program by Nov. 15, 2005 – Item 322 #1c

Funding of \$1 million GFs to the Virginia Health Care Foundation including \$350,000 specifically for medication assistance coordinators (funding is in addition to the \$350,000 added in the Governor's Budget); Item 314 #1c

Our budget amendment was for \$350,000 GFs for medication assistance coordinators

Language requiring DMAS to exclude antidepressants and antianxiety medications from the Medicaid preferred drug list – Item 326 #4c

2005 JCHC Budget Amendments Included in the Approved Budget

Prescription assistance for free clinics – Item 312 #2c	\$400,000 GFs (\$778,600 GFs requested)
Prescription assistance for community health centers – Item 312 #3c	\$200,000 GFs (\$110,000 GFs requested)
VDH follow-up activities related to expansion of newborn screening – Item 313 #1c	\$952,807 NGFs (\$954,000 GFs requested)
VDA to establish 3 guardianship programs – Item 301 #1c	\$132,000 GFs (\$187,500 GFs requested)
DMHMRSAS for legal and medical examinations for 60 individuals – Item 332 #1c	\$50,000 GFs (\$120,000 GFs requested)

2005 Budget Amendments Not Included in the Conference Report

Increase the Personal Maintenance Allowance for Medicaid waivers to 300% of SSI
\$4.3 million GFs & \$4.3 million NGFs (DMAS)

Increase Medicaid Reimbursement of Physicians to Medicare Rate
\$87 million GFs & \$87 million NGFs (DMAS)

Fund the outpatient reporting system developed by VHI
\$50,000 GFs (VDH)

Fund a public education/awareness campaign regarding HSAs
\$25,000 GFs (VDH)
\$5,000 GFs to (VDBA)

2005 Budget Amendments Not Included in the Conference Report

Establish 2 prison re-entry programs
\$1,131,000 GFs (DMHMRSAS)

Develop and fund a reporting system for acute psychiatric beds for children and adolescents
\$75,000 GFs (DMHMRSAS)

Fund increase in auxiliary grant to \$1250 per month
\$29.8 million GFs for grant increase (DMAS)
\$10.5 million GFs and \$10.5 million NGFs for increased Medicaid costs (DMAS)
\$13.6 million GFs to eliminate local match (DMAS)

Eliminate the local match if AG is not increased
\$6.1 million GFs (DMAS)

II. EXECUTIVE SUMMARIES OF 2004 JCHC REPORTS

USE/DISCLOSURE OF HEALTH RECORDS UNDER VIRGINIA LAW AND HIPAA EXECUTIVE SUMMARY

Authority for Study

HJR 134 directed JCHC to “study the use and disclosure of health records relative to Virginia law and the Health Insurance Portability and Accountability Act (HIPAA)” in order to “consider the need for amendments to Virginia laws and recommend ways to assist health care providers and other relevant parties to understand and comply with state and federal health record privacy laws.”

Background on the HIPAA Privacy Rule

The Privacy Rule, promulgated under the federal Health Insurance Portability and Accountability Act of 1996, imposed new requirements for HIPAA-covered entities to ensure the privacy of health records including the use and disclosure of health records. As a general principle, HIPAA supervenes state health privacy laws which make it (a) more difficult for an individual to access his own records than would HIPAA or (b) easier for a third party to access an individual’s health records than would HIPAA. There are a number of instances in which it is unclear whether HIPAA privacy provisions or Virginia law take precedence.

JCHC Study

A study effort was undertaken on behalf of JCHC and led by representatives of the Health Law Section of the Virginia Bar Association (VBA). Workgroups, including members of VBA and representatives of the Administration, the Attorney General’s Office, and various interest groups, deliberated and made recommendations regarding legislation to address conflict between HIPAA and State statute. The workgroups’ recommendations are

described in the Executive Summary of the final report. In general, changes to Virginia laws were recommended related to access and disclosure of records including minor's records, treatment of psychotherapy notes, allowable charges for copying health records, and the repeal of Chapter 12 of Title 37.1 (which addressed disclosure of patient information to third-party payors by providers of mental health, mental retardation or substance abuse services).

REVIEW OF NEWBORN SCREENING IN VIRGINIA EXECUTIVE SUMMARY

Authority for Study

HJR 164 directed the Joint Commission on Health Care (JCHC) to review information regarding newborn screening (NBS) programs for metabolic disorders including the disorders screened in other states, and the benefits and the costs associated with screenings. The collected information and an executive summary are required to be submitted prior to the 2005 General Assembly Session for processing as a legislative document.

NBS Programs in Other States and Anticipated New Federal Guidelines

Newborn screening programs began in the 1960s, after the effects of PKU were identified and a method was developed to preserve blood samples on filter paper, an inexpensive, simple means of screening a large number of newborns. Although NBS is conducted in each of the 50 states, there is currently no uniformity in the number of disorders screened with 3 to 54 disorders being screened. The lack of uniformity is due in part to the absence of federal requirements related to NBS. Currently, the federal recommendation is for newborns to be screened for PKU, congenital hypothyroidism, and sickle cell diseases. However, it is anticipated that the Secretary of Health and Human Services (HHS) will issue a new recommendation based on the findings of a recently released study by the American College of Medical Genetics (ACMG) with Michael S. Watson Ph.D. as primary author. The 3-year ACMG study to develop a uniform list of disorders for states to include in NBS screening programs was presented in September 2004 to an Advisory Committee on Heritable Disorders and Genetic Diseases in Newborns or Children (established

by the HHS Secretary). The ACMG study recommended screening for a core panel of 30 disorders with 25 additional disorders being report-only disorders. (Virginia screens for 12 of the 30 disorders as they are listed in the ACMG study.) It is expected that the HHS Secretary will recommend that states include a NBS panel of disorders that is different by only one or two disorders from the ACMG's initial study recommendation.

Reaction to the Anticipated Expansion of NBS Panels

On September 22, 2004, the March of Dimes revised its NBS recommendation from 9 disorders to the 30 disorders recommended in the ACMG study.

Expansion is supported by a number of Virginia-based associations including: VA Chapter of March of Dimes, VA Chapter of American Academy of Pediatrics, VA Association of Health Plans, VA Hospital & Healthcare Association (VHHA), VA Genetic Advisory Committee (VaGAC) and DMAS. VHHA indicated however the need for the societal benefits to be borne "fairly by all those who benefit." VaGAC, which is charged with recommending changes in the NBS program to the VA Board of Health suggests limiting the initial expansion to the disorders that can be tested on the tandem mass spectrometer to allow for further study on screening of cystic fibrosis (CF) and Glucose 6 Phosphate Deficiency (G6PD).

Expansion of the NBS Panel in Virginia

The Division of Consolidated Laboratory Services (DCLS) within the Department of General Services completes the NBS testing. DCLS has the equipment to complete testing for 28 of the 30 disorders included in the ACMG study (exceptions are CF and G6PD). A few additional staff with expertise in interpreting screening results will be needed. VDH (with DCLS) will need to educate and provide technical assistance to providers, expand databases, and enhance services for children who are medically indigent children or have certain disorders. VDH contracts with EVMS, UVA, and VCU to provide expert consultation, diagnostic testing, and treatment will need to be expanded.

Even if the decision is made to expand NBS as soon as possible, there will be a delay (likely to be until March 2006) before the expanded screening will be implemented. Virginia Newborn Screening Services and DCLS in cooperation with VaGAC will be adding information regarding expanded, supplemental screening options to their NBS pamphlet. The pamphlet is typically given to parents of newborns in hospitals. However, efforts are underway to provide the pamphlets to parents during the prenatal period. Moreover, information about expanded, supplemental screening options will be included on the VDH website.

Actions Taken by JCHC

Six policy options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted in support of the following three options:

Option III: Introduce legislation to amend the *Code of Virginia*, Title 32.1 Chapter 2 to expand Virginia's panel for newborn screening to include all of the disorders recommended by the Secretary of Health and Human Services (effective date March 2006).

Option IV: Introduce a budget amendment for as much as \$1.15 million in general funds to fund ~~all or~~ a portion of the expanded screening for FY 2006. Include on the 2005 workplan of the Joint Commission, consideration of continued funding of the expanded program.

Option V: Introduce a budget amendment (language only) directing the Department of General Services to increase newborn screening user fees to fund ~~all or a testing~~ portion of the expanded screening. (It is estimated that an increase from \$32/filter to a range of \$41 to \$48 per filter would fund the screening-related activities ~~while an increase of an additional \$4.50 or \$6.00 per filter would fund screening, educational, and follow up activities~~).

PRESCRIPTIVE AUTHORITY OF PHYSICIAN ASSISTANTS

EXECUTIVE SUMMARY

Authority for Study

House Bill 2318 (HB 2318) of the 2001 General Assembly Session expanded the prescriptive authority for physician assistants (PAs). Specifically, the prescriptive authority for PAs changed from the authority to prescribe only Schedule VI drugs to a time table (over a period of several years) for the authority to prescribe Schedules IV-VI drugs. An enactment clause in HB 2318 required the Joint Commission on Health Care to provide a report on the issue of prescriptive authority for PAs prior to the 2005 General Assembly Session. Specifically, the Commission is required by the enactment clause:

...to study physician assistant prescriptive authority as provided in this act to determine the impact of the authority to prescribe Schedules IV through VI controlled substances and devices on patient care, provider relationships, third-party reimbursement, physician practices, and patient satisfaction with physician assistant treatment.

It should be noted that House Bill 2205 (HB 2205) of the 2003 General Assembly Session also expanded the prescriptive authority of PAs. HB 2205 provided PAs with the authority to prescribe Schedule III controlled substances on or after July 1, 2004.

Growth in the Number of Physician Assistants

The number of PAs in Virginia has increased more than 90 percent between 1999 and late-March 2004. As of late-March 2004, there were 957 licensed PAs in Virginia. The number of PAs with prescriptive authority was 697, appearing that almost 73 percent of PAs have prescriptive authority. Because only 771 of the 957 licensed PAs are engaged in active practice, the number of eligible PAs with prescriptive authority would actually be closer to 90 percent.

Virginia Data on Physician Assistants

The Board of Medicine (BOM) collects some information about its licensees including PAs and their practice locations. Having information regarding the practice location of PAs allows a comparison to the primary care health professional shortage areas (HPSAs). JCHC staff compared the PA addresses that were provided to the BOM with the primary care HPSAs. This comparison

of data found that 94 records or 9.9 percent of records listed work addresses that were found to be in designated primary care HPSAs. (Analysis of 950 of 989 PA records listing a Virginia address were matched to a census tract). Seventy-two records or about 7.6 percent of records of PAs with prescriptive authority listing a Virginia address listed addresses that were found to be in primary care HPSAs.

Information concerning PA primary practice specialty is not collected. This information would be useful in comparing the locations in which PAs practice, the practice locations that are within a HPSA, and the practice specialties that are represented.

Information on Other States

Three states allow no prescriptive authority for PAs; Ohio, Louisiana, and Indiana. Twenty-eight states allow PAs to prescribe up to Schedule II controlled substances with physician involvement (although some states may have restrictions and/or formularies). Eleven states allow PAs to prescribe drugs through Schedule III controlled substances (although some states may have restrictions and/or formularies). A small number of states allow prescription of the lower schedules of controlled substances, a formulary of authorized drugs, or non-controlled substances.

At the time of this study, Virginia was in the mid-range of the level of prescriptive authority allowed to PAs in comparison to other states, but moved up by authorizing as of July 1, 2004, PAs to prescribe Schedule III through VI controlled substances. The level of supervision required for PAs varies widely between states. Although some states require direct, on-site supervision, most do not. Other states allow for supervisory contact via some type of telecommunication. There are also stipulations in some states for chart review or cosigning within a variety of time-periods. Virginia requires continuous supervision, but the physician does not have to be physically present at all times.

Mandated Areas of Study

With regard to areas mandated for study, JCHC staff found:

- A number of studies conducted in the United States have shown that quality care is being provided by PAs. Moreover, it is likely that the increase in PA prescriptive authority in Virginia has had a positive impact on patient care.

- The research on provider relationships is ambiguous; making further extrapolation to the impact increased PA prescriptive authority has had on provider relationships difficult.
- Reimbursement of PA services depends on the category of payer. Currently, under the Virginia Medicaid program, PAs do not receive direct reimbursement.
- The impact that the increase in PA prescriptive authority has had on physician practices is closely tied with other previous categories (for instance, physician practices are impacted by provider relationships). Physicians in practice were impacted in their day-to-day operations if they employed PAs when the PA prescriptive authority increased. Some individuals contacted as part of the study indicated that the prescriptive authority was beneficial to physicians and PAs in that it reduced some burdens. Some of these decreases in burdens likely increased the efficiency of some physician practices.

A number of studies indicated that patient satisfaction exists with PA services generally. In addition, anecdotal evidence suggested that patient satisfaction with regard to PA prescriptive authority was high.

Actions Taken by JCHC

Three policy options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted to take no action.

MENTAL HEALTH NEEDS AND TREATMENT OF YOUNG MINORITY ADULTS INTERIM REPORT EXECUTIVE SUMMARY

Authority for Study

Senate Joint Resolution 25 (2004) directed the Joint Commission on Health Care (JCHC) to “study the mental health needs and treatment of young minority adults in the Commonwealth.” This is a two-year study with an interim report due by the first day of the 2005 session. The final report, a document which will

include findings and recommendations, will be submitted to the Governor and the General Assembly by the first day of the 2006 session.

Provisions of SJR 25

SJR 25 requires to Joint Commission on Health Care in conducting the study to:

- Estimate the “number of mentally disabled young adults by gender, age, and racial and ethnic classification, in the geographic regions of the Commonwealth.”
- Identify the “prevailing mental health and emotional disorders and their etiology among minority young adults [and]...the mental health needs of minority citizens, particularly minority young adults in Virginia.”
- Determine the “number of racial and ethnic minority persons who receive mental health treatment...and the facilities providing such care.”
- Ascertain whether “mental health providers are trained to provide culturally competent mental health treatment” and the level of need for such treatment in Virginia.
- Review “federal and state laws and regulations...and identify the...extent to which medical records information may be disclosed to parents and family members to assist them in obtaining health, social services, and mental health treatment for mentally disabled young adults” and recommend ways to provide information to allow family members to obtain services and treatment without resorting to involuntary commitment.

The study will be completed within the context of a workgroup including individuals who are knowledgeable and concerned about mental health issues and minority access to treatment.

BENEFITS OF PUBLIC-PRIVATE PARTNERSHIPS TO MEDICAID RECIPIENTS EXECUTIVE SUMMARY

Authority for Study

Senate Joint Resolution (SJ) 58 of the 2004 Session of the General Assembly directed the Joint Commission on Health Care to study how other states have succeeded in improving services and lowering health care and prescription drug costs to Medicaid recipients through public-private partnerships. Specific areas the study addresses include:

- Other states' programs for reducing the costs of healthcare and prescription drugs through agreements with the private sector which should specifically address disease management programs;
- Florida's Medicaid Initiative and Disease Management Initiative; and
- Options regarding the feasibility of implementing Medicaid disease management programs as a cost-containment strategy in Virginia.

This report is being submitted to the Governor and the General Assembly.

State Strategies to Control Medicaid Pharmaceutical Costs

In response to the increasing burden of Medicaid pharmaceutical costs on State budgets, the majority of states is considering or has enacted changes to control rising drug expenditures. Most of the strategies employed center on new or expanded application of management tools that the federal government allows under existing law. A multitude of strategies are used by states including:

- Prior authorization;
- Preferred drug lists (PDL);
- Supplemental rebates from manufacturers;
- Multi-state pharmaceutical purchasing pools;
- Generic substitution;
- Drug utilization review (DUR); and
- Pricing strategies.

The Department of Medical Assistance Services currently applies all of the strategies listed above, with the exception of multi-state pharmaceutical purchasing pools. In addition to the previously listed strategies, some states also employ disease management programs as a cost-containment measure.

Medicaid Disease Management Programs

According to the Centers for Medicare and Medicaid Services, 20 states operate Medicaid disease management programs. There is a great deal of variation in the type and scope of these programs. States have implemented disease management programs as a state plan service, under waiver authority, and with the use of supplemental drug rebates.

One of the methods used by Florida to provide disease management consists of using value-added programs provided through supplemental rebates from drug manufacturers. Pharmaceutical manufacturers participating in this program include Pfizer, Bristol-Myers Squibb, AstraZeneca, and GlaxoSmithCline. Under these contracts, pharmaceutical manufacturers provide disease management services instead of monetary supplemental rebates. Original calculations estimated that the four pharmaceutical companies combined programs would save Florida \$108.4 million from July 2002 through September of 2005. A report issued by the Florida Office of Program Policy Analysis and Government Accountability (OPPAGA) in April of 2003, estimated that the state could save \$64.2 million in 2003 and 2004 by requiring the four drug companies to provide traditional supplemental rebates instead of disease management programs. An additional report issued in May 2004 by OPPAGA, estimated that Florida's disease management initiative had only saved \$13.4 million, far below the original estimate of \$108.4 million. The Florida Agency for Health Care Administration (AHCA), the state entity administering the Medicaid program, disagreed with the analysis conducted by OPPAGA in 2003 and 2004. AHCA questioned the methodology and assumptions used by OPPAGA to reach their final conclusions. However, on May 28, 2004, the Governor signed House Bill 1843, which prohibits value-added programs, such as disease-management from being used as a substitute for cash supplemental rebates.

The Virginia Department of Medical Assistance Services has also been involved in several initiatives to provide disease management to both the fee-for-service and managed care populations. Programs outlined in this report specifically address fee-for-service Medicaid disease management initiatives.

The Virginia Health Outcomes Project (VHOP), a pilot project in the Richmond area, began serving recipients in DMAS' primary care case management program, MEDALLION, in 1993. With the participation of six pediatricians in the Richmond area, the program sought to educate these physicians treating recipients with asthma, on clinically sound and evidence-based treatments. Initial cost-savings calculations concluded that for every \$1 spent \$3 in treatment costs were saved. However, questions were raised about the methods used to calculate cost-savings and DMAS reported significant administrative costs associated with the program.

In 1997, Heritage Information Systems, Inc. was awarded a contract to design, implement, and evaluate disease management services in the fee-for-service Medicaid program. In June 1999, the disease management program was implemented. An analysis by Heritage Information Systems, Inc. showed a rate of return on investment of \$1.75 for every \$1 spent.

During the 2002-2004 biennium, DMAS was directed to create a statewide disease management program. DMAS was expected to produce \$22 million in savings from initial funding of \$1.4 million. Several difficulties in implementing the program were reported by DMAS, including:

- Funds budgeted for the program were limited;
- Growing evidence that significant savings from disease management programs are not usually seen in the two-year budget cycle DMAS was working under; and
- Lack of vendors who were willing to guarantee savings.

DMAS has entered into a contract with the Anthem subsidiary Health Management Corporation, Inc. (HMC) to implement and evaluate the pilot Healthy Returns Disease Management Program. From June 1, 2004 to May 30, 2005, the program will target fee-for-service recipients with a diagnosis of

coronary heart disease or congestive heart failure. The program will be evaluated by Health Management Corporation, Inc.

In addition to these disease management programs for the fee-for-service Medicaid population, all of DMAS' managed care programs have disease management programs. Currently more than half of the Medicaid population is served through managed care.

Actions Taken by JCHC

Three policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. The Commission voted to support Option III to introduce a budget amendment directing DMAS to report to JCHC by October 1, 2005 on the results of the Healthy Returns Disease Management Program and the feasibility of expanding the program.

HEALTHY LIVES PRESCRIPTION ASSISTANCE PROGRAM EXECUTIVE SUMMARY

Authority for Study

House Bill 2225 and Senate Bill 1341, identical bills, enacted during the 2003 General Assembly Session amended the *Code of Virginia* to establish the Healthy Lives Prescription Assistance Fund under the auspices of the Secretary of Health and Human Resources to "accept appropriations, donations, grants, and in-kind contributions to develop and implement programs that will enhance current prescription programs for citizens of the Commonwealth who are without insurance or the ability to pay for prescription drugs and to develop innovative programs to make such prescription drugs more available." In addition, HB 2225 and SB 1341 include a second enactment clause that requires the Joint Commission on Health Care to prepare a Plan "to provide prescription drug benefits for low-income senior citizens and persons with disabilities...."

To develop recommendations for the Plan, a diverse group of interested parties, representing advocacy groups, health care providers and associations, pharmaceutical manufacturers, state agencies, and the Secretary of Health and Human Resources participated in workgroup meetings during the summer of 2003. Based on recommendations from this group, JCHC on November 12, 2003 unanimously approved a two-phased design for the Healthy Lives Prescription Plan.

Phase I included such activities as informing seniors and their families regarding the existence of pharmaceutical discount cards and affiliating with opportunities that currently exist in the community to provide assistance in filling out applications.

Implementation of Phase II included the following activities:

- Monitoring the actions of Congress regarding a Medicare prescription drug benefit;
- Examining what other states are doing to assist seniors;
- Encouraging Virginia-based initiatives such as The Pharmacy Connection;
- Continuing to develop partnerships with community-based entities such as pharmacies, faith-based organizations, human service agencies, and advocacy associations; and
- Analyzing potential legislation to increase the income limits for Medicaid eligibility in Virginia.

Actions Taken by JCHC

Ten policy options were offered for consideration by the Joint Commission on Health Care. On November 15, 2004, the Commission voted in support of six of the options including:

- **Option II:** Introduce a joint resolution requesting the Virginia Department for the Aging and the Virginia Department of Health to provide information on the “wrap around” coverage currently offered by private pharmaceutical companies. This coverage is available for low-

income individuals enrolled in the Medicare prescription drug discount card program who use all of their \$600 transitional assistance credit.

- **Option IV:** Introduce a budget amendment (language and funding) to expand the use of The Pharmacy Connection software to other areas of the state.
- **Option V:** Introduce a joint resolution requesting the Department for the Aging, the Department of Medical Assistance Services, and the Department of Health to work with the Virginia Dental Association and the Virginia Health Care Foundation in exploring the feasibility of using the Mission of Mercy initiative as a vehicle for expanding access to and information about pharmaceutical assistance programs and Medicare prescription drug discount cards.
- **Option VIII:** Continue to address the development of the Healthy Lives Prescription Plan by including the issue on the JCHC workplan for 2005.
- **Option IX:** Introduce a budget amendment (language and funding) to increase funding for the acquisition and provision of prescription medications to Free Clinic patients.
- **Option X:** Introduce a budget amendment (language and funding) to increase funding for the Virginia Primary Care Association Indigent Pharmacy Assistance Program.

APPENDIX A

Joint Commission on Health Care 2005 Legislation

Bills

HB 1492/ SB 1097	Amend and reenact §§ 38.2-5601 and 38.2-5602 of the Code of Virginia, to amend the Code of Virginia by adding a section numbered 38.2-5602.1, and to repeal §§ 38.2-5600 and 38.2-5603 of the Code of Virginia, relating to the Virginia Health Savings Account Act. Both bills were approved and appear as <i>2005 Acts of Assembly</i> Chapters 572 and 503 respectively.	1/ 54
HB 2363/ SB 1064	Amend and reenact the § 32.1-127.1:03 of the <i>Code of Virginia</i> relating to health records privacy. Both bills were approved and appear as <i>2005 Acts of Assembly</i> Chapters 101 and 39 respectively.	9/ 47
HB 2511/ SB 1184	Amend Title 32.1 to expand Virginia's panel for newborn screening to include additional disorders. HB 2511 was incorporated into HB 1824 (which was approved by the General Assembly and signed by the Governor). SB 1184 was approved and appears as <i>2005 Acts of Assembly</i> Chapter 717.	16/ 67
HB 2512/ SB 1187	Requires administrators of assisted living facilities to be licensed by the Board of Long-Term Care Administrators within the Department of Health Professions (effective July 1, 2007). In addition, the bill permits the Commissioner to issue an order of summary suspension of a license to operate an assisted living facility in cases of immediate and substantial threat to the health, safety, and welfare of residents or participants. The bill increases the maximum civil penalties for assisted living facilities from \$500 to \$10,000 per inspection and directs that the civil penalties be placed in the newly created Assisted Living Facility Education and Technical Assistance Fund to fund staff training and technical assistance for assisted living facilities. HB 2512 was approved and appears as <i>2005 Acts of Assembly</i> Chapter 924. SB 1187 was incorporated into SB 1183 (which was approved by the General Assembly and signed by the Governor).	18/ 69

<p>Joint Commission on Health Care 2005 Legislation</p>
--

HB 2513/ SB 1041	Employer provided long-term care insurance tax credit. Grants an income tax credit to business taxpayers that provide long-term insurance for employees. The annual credit allowed is 10 percent of the costs of the long-term care insurance premiums but no more than (i) a total of \$5,000 or (ii) \$100 per employee, whichever is less. Both bills were left in the Senate Finance Committee.	31/ 46
HB 2514/ SB 1110	Disclosure of patient information by certain health care providers. Repeals provisions governing disclosure of patient information to third party payors by mental health, mental retardation, and substance abuse professionals. This bill is a recommendation of the Joint Commission on Health Care. Both bills were approved and appear as 2005 <i>Acts of Assembly</i> Chapters 111 and 43 respectively.	32/ 66
HB 2515/ SB 1203	Copying Charges for Medical Records. Amend and reenact §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the <i>Code of Virginia</i> regarding copying charges for medical records. Both bills were approved and appear as 2005 <i>Acts of Assembly</i> Chapters 642 and 697.	33/ 73
HB 2516/ SB 1109	Minors' Records. Amend and reenact the §§ 16.1-338, 54.1-2969, 20-124.6, and 2.2-3705.5 of the <i>Code of Virginia</i> relating to health records privacy related to minors' records. Both bills were approved and appear as 2005 <i>Acts of Assembly</i> Chapters 181 and 227 respectively.	42/ 62

Resolutions

HJR 701	"Wrap-around" Medicare prescription drug coverage. Encourages the Commissioner of the Department for the Aging and the Commissioner of Health to include specifics on wrap-around coverage provided to the public in their Medicare prescription drug information. HJR 701 was adopted by the General Assembly.	82
---------	---	----

**Joint Commission on Health Care
2005 Legislation**

HJR 702/ SJR 363	Feasibility of information distribution by Mission of Mercy. Encourages the departments for the Aging, Medical Assistance Services, and Health to work with the Virginia Dental Association and the Virginia Health Care Foundation on using the Mission of Mercy program to disseminate information on prescription assistance programs and Medicare prescription drug discount cards. Both resolutions were adopted by the General Assembly.	83/ 84
---------------------	---	-----------

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 572

An Act to amend and reenact §§ 2.2-2818, 6.1-2.9:8, 38.2-5601, and 38.2-5602 of the Code of Virginia, to amend the Code of Virginia by adding a section numbered 38.2-5602.1, and to repeal §§ 38.2-5600 and 38.2-5603 of the Code of Virginia, relating to health savings accounts; the Virginia Health Savings Account Plan; high deductible health plans.

[H 1492]

Approved March 22, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 6.1-2.9:8, 38.2-5601, and 38.2-5602 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-5602.1 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. (Contingent expiration date) 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 physician, (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;

a. (Contingent effective date) 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.

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 subdivision 1, 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 subdivision 1, 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.

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

The reimbursement for patient costs incurred during participation in clinical trials for treatment

studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

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

"FDA" means the Federal Food and Drug Administration.

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

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

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

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

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

- a. The National Cancer Institute;
- b. An NCI cooperative group or an NCI center;
- c. The FDA in the form of an investigational new drug application;
- d. The federal Department of Veterans Affairs; or
- e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

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

Coverage under this section shall apply only if:

- (1) There is no clearly superior, noninvestigational treatment alternative;
- (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the ~~noninvestigational~~ noninvestigational alternative; and
- (3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

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

18. Include coverage for biologically based mental illness.

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

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage 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 copayment and 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. (Contingent expiration date) 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 or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

22. (Contingent effective date) 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, 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.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in

§ 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Ombudsman shall:

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

2. Answer inquiries from covered employees by telephone and electronic mail.
3. Provide to covered employees information concerning the state health plans.
4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.
5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.
6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.
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. 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.

O. 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.

§ 6.1-2.9:8. Medical savings accounts and health savings accounts.

To the extent allowed by federal law, a bank, insured savings institution, or credit union may act as a trustee or custodian of *health savings accounts established with financial institutions under § 223 of the United States Internal Revenue Code of 1986, as amended from time to time, and medical savings accounts established with financial institutions under § 220 of the United States Internal Revenue Code of 1986, as amended from time to time.* Contributions may be accepted and interest thereon retained by such institution pursuant to forms provided by it and may be invested in accounts of the institution in accordance with the terms upon which such contributions were accepted. The financial institution shall administer such accounts in accordance with the requirements of federal law.

CHAPTER 56.

THE VIRGINIA ~~MEDICAL~~ HEALTH SAVINGS ACCOUNT ~~ACT~~ PLAN.

§ 38.2-5601. The Virginia Health Savings Account Plan.

A. The Department of Taxation and the ~~Bureau of Insurance Commission~~ shall ~~develop~~ amend the Virginia Medical Savings Account Plan *prepared pursuant to former § 38.2-5600 in order to address the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, permitting eligible individuals to establish health savings accounts pursuant to § 223 of the Internal Revenue Code of 1986, as amended, which amended Plan shall be designated as the Virginia Health Savings Account Plan. The Department of Taxation and the Commission shall present the Virginia Health Savings Account Plan to the chairs of the House Appropriations; Finance; Health, Welfare and Institutions; and Commerce and Labor Committees and the Senate Finance; Education and Health; and Commerce and Labor Committees by January 1, 2006. Thereafter the Department of Taxation and the Commission shall update the Plan annually and provide copies of such updates to the chairs of such committees.*

B. The Virginia Health Savings Account Plan shall set forth the requirements for establishing

~~medical, consistent with federal law authorizing the establishment and use of health savings accounts, identify measures by private and public entities that will increase the utilization and efficacy of health savings accounts; which shall include, but not be limited to by the Commonwealth's residents, employers, and providers of health care coverage. The Plan shall include recommendations for legislation that would increase the attractiveness of health savings accounts, or eliminate barriers to their use, by providing:~~

- ~~a. Definitions of eligible participants;~~
- ~~b. Criteria for accounts, including, but not limited to, such matters as trustees, maximum amounts, etc. and the rollover of balances in medical savings accounts to health savings accounts;~~
- ~~c. A system for providing a viable sliding scale for refundable tax credits for the working poor.~~
- ~~d. A system for allowing voluntary employer contributions to the medical savings accounts and tax deductions for such contributions.~~
- ~~e. A system for allowing tax credits for health care practitioners providing services to holders of medical savings accounts at reduced cost or without compensation.~~
- ~~f. c. Measures that would encourage public and private employers to offer, as part of a cafeteria menu of insurance plans to provide, high-deductible, indemnity health insurance policies, health plans that would qualify for a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended; and~~
- ~~g. d. Any other specific provisions necessary appropriate to the efficient implementation of the Virginia Medical Savings Account Plan maximize the use of health savings accounts within the Commonwealth.~~

~~C. The Plan shall include a report by the Commission on the availability of high deductible health plans, as defined in § 223 (c) (2) of the Internal Revenue Code of 1986, as amended, in the Commonwealth.~~

~~D. The Plan shall include recommendations by the Department of Taxation for a system of income tax deductions or refundable credits, consistent with federal law and regulation, for (i) employers who voluntarily contribute to their employees' health savings accounts, (ii) health care providers who participate in providing care to health savings account holders at a reduced cost or without compensation, and (iii) eligible individuals, as defined in § 223 (a) of the Internal Revenue Code of 1986, as amended, who qualify under applicable federal or state definitions as members of the working poor.~~

§ 38.2-5602. Operation of medical savings accounts.

Medical savings accounts may be established in the Commonwealth, and may be converted to health savings accounts, pursuant to applicable federal law and regulation.

§ 38.2-5602.1. Operation of health savings accounts; high deductible health plans.

Health savings accounts may be established in the Commonwealth pursuant to applicable federal law and regulation. Unless otherwise prohibited by any provision of this title, any health carrier, as defined in § 38.2-5800, authorized to conduct business in the Commonwealth may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

2. That §§ 38.2-5600 and 38.2-5603 of the Code of Virginia are repealed.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 101

An Act to amend and reenact § 32.1-127.1:03 of the Code of Virginia, relating to health records privacy.

[H 2363]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127.1:03 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by ~~another provision~~ other provisions of state or federal law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care.

"Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health

care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;
2. Except where specifically provided herein, the health records of minors; or
3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may, *and, when required by other provisions of state law, shall*, disclose health records:

1. As set forth in subsection E of ~~this section~~, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; ~~also, or (b) the minor himself, if he has consented to his own treatment pursuant to subsection E of § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;~~

2. In compliance with a subpoena issued in accord with subsection H of ~~this section~~, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509 and 63.2-1606;

7. Where necessary in connection with the care of the individual, ~~including in the implementation of a health care provider's routine contact process pursuant to subdivision B 4 of § 32.1-127;~~

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Article 1.1 (§ 37.1-134.6 et seq.) of Chapter 4 of Title 37.1;

12. To the attorney appointed by the court to represent an individual who is or has been a patient

who is the subject of a civil commitment proceeding under § 37.1-67.3 or a judicial authorization for treatment proceeding pursuant to § 37.1-134.21;

13. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

14. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

15. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

16. To third-party payors and their agents for purposes of reimbursement;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. ~~To the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413~~ *Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;*

21. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

23. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

25. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Chapter 16 (§ 37.1-255 et seq.) of Title 37.1;

26. (Expires July 1, 2006) To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision D 1 of this ~~section~~ *subsection*;

27. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

28. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title; and

29. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment.

Notwithstanding the provisions of subdivisions 1 through 29 of this subsection, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of

§ 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of this Code, federal law or state or federal regulation law.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name
Health Care Entity's Name
Person, Agency, or Health Care Entity to whom disclosure is to be made
Information or Health Records to be disclosed
Purpose of Disclosure or at the Request of the Individual

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession

of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event)

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

Relationship or Authority of Legal Representative

Date of Signature

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9 of this subsection, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8 of *this subsection*.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in ~~subdivisions~~ *subdivision 5* or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative

agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

051523136

HOUSE BILL NO. 2511

Offered January 12, 2005

Prefiled January 12, 2005

A BILL to amend and reenact §§ 32.1-65 through 32.1-67.1 of the Code of Virginia and to repeal the second enactment of Chapter 440 of the 2002 Acts of Assembly, relating to newborn screening services.

Patrons—Welch, Plum, Athey and O'Bannon

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-65 through 32.1-67.1 of the Code of Virginia are amended and reenacted as follows:

Article 7.

Detection and Control of Phenylketonuria and Other Inborn Errors of Metabolism Newborn Screening.

§ 32.1-65. Certain newborn screening required.

In order to prevent mental retardation, and permanent disability or death, every infant who is born in this the Commonwealth shall be subjected to a screening test for biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, congenital adrenal hyperplasia, medium-chain acyl-CoA dehydrogenase (MCAD or MCADH) deficiency, and Maple Syrup Urine Disease, and each infant determined at risk shall be subject to a screening test for sickle cell diseases tests for various disorders consistent with, but not necessarily identical to, the uniform condition panel recommended by the American College of Medical Genetics in its 2004 report, Newborn Screening: Toward a Uniform Screening Panel and System, that was produced for the U.S. Department of Health and Human Services. Further, upon the issuance of guidance for states' newborn screening programs by the federal Department of Health and Human Services, every infant who is born in the Commonwealth shall be screened for a panel of disorders consistent with, but not necessarily identical to, the federal guidance document.

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

The physician or certified nurse midwife in charge of the infant's care after delivery shall cause such test tests to be performed. The screening tests shall be performed by the Division of Consolidated Laboratory Services or any other laboratory the Department of Health has contracted with to provide this service.

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

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

Whenever a newborn screening test result indicates suspicion of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease or any sickle cell disease any condition pursuant to § 32.1-65, the Commissioner shall notify forthwith the attending physician and shall perform or provide for any additional testing required to confirm or disprove the diagnosis of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease or the sickle cell disease. All physicians, certified nurse midwives, public health nurses, or any nurse receiving such test result, and administrators of hospitals in this the Commonwealth, shall report the discovery of all cases of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease any condition for which newborn screening is conducted pursuant to § 32.1-65 to the Commissioner, as well as sickle cell diseases in infants less than one year of age for infants and children up to two years of age.

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

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

INTRODUCED

HB2511

1/19/05 13:48

59 deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease
60 and sickle cell diseases; and shall provide such treatment for infants in medically indigent families. The
61 Board shall create procedures to provide to (i) the parents or guardian of any child or (ii) any pregnant
62 woman, who is a legal resident of the Commonwealth and who is diagnosed as requiring treatment for
63 phenylketonuria, the special food products required in the management of phenylketonuria out of such
64 funds as may be appropriated for this purpose. The special food products shall include medical formulas
65 which are designed specifically for the treatment of phenylketonuria and low protein modified foods (not
66 foods naturally low in protein) which are designed specifically for use in the treatment for inborn errors
67 of metabolism. The parents or guardian of any such child, or the pregnant woman, shall, in the
68 discretion of the Department, reimburse to the local health department the cost of such special medical
69 formulas in an amount not to exceed two percent of their gross income. The parents or guardian of any
70 such child, or the pregnant woman, shall, with such funds as are appropriated, receive reimbursement
71 from the Department for the cost of such special low protein modified foods in an amount not to exceed
72 \$2,000 per diagnosed person per year. The reimbursement required by this section shall be payable
73 quarterly by the first day of January, April, July, and October.

74 § 32.1-67.1. Confidentiality of records; prohibition of discrimination.

75 The results of the *newborn screening programs services* conducted pursuant to this article may be
76 used for research and collective statistical purposes. No publication of information, biomedical research,
77 or medical data shall be made ~~which~~ *that* identifies any infant having a ~~genetic disease heritable or~~
78 *genetic disorder*. All medical records maintained as part of *newborn screening services* ~~the screening~~
79 ~~programs~~ shall be confidential and shall be accessible only to the Board, the Commissioner, or his
80 agents.

81 **2. That the second enactment of Chapter 440 of the 2002 Acts of Assembly is repealed.**

82 **3. That the provisions of this act shall become effective on March 1, 2006.**

83 **4. That, notwithstanding the provisions of the third enactment clause, the Board of Health shall**
84 **promulgate regulations to implement the provisions of this act to be effective within 280 days of its**
85 **enactment.**

VIRGINIA ACTS OF ASSEMBLY -- 2005 RECONVENED SESSION

CHAPTER 924

An Act to amend and reenact §§ 2.2-703, 54.1-2503, 54.1-3005, 54.1-3007, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103, 54.1-3408, 63.2-1702, 63.2-1707, 63.2-1709, 63.2-1721, 63.2-1732, 63.2-1803, and 63.2-1805 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 30 of Title 54.1 an article numbered 7, consisting of sections numbered 54.1-3041, 54.1-3042, and 54.1-3043, by adding in Chapter 31 of Title 54.1 a section numbered 54.1-3103.1, and by adding sections numbered 63.2-1709.1, 63.2-1709.2, and 63.2-1803.1, relating to assisted living facilities; civil penalty.

[H 2512]

Approved April 6, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-703, 54.1-2503, 54.1-3005, 54.1-3007, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103, 54.1-3408, 63.2-1702, 63.2-1707, 63.2-1709, 63.2-1721, 63.2-1732, 63.2-1803, and 63.2-1805 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 30 of Title 54.1 an article numbered 7, consisting of sections numbered 54.1-3041, 54.1-3042, and 54.1-3043, by adding in Chapter 31 of Title 54.1 a section numbered 54.1-3103.1, and by adding sections numbered 63.2-1709.1, 63.2-1709.2, and 63.2-1803.1 as follows:

§ 2.2-703. Powers and duties of Department with respect to aging persons; area agencies on aging.

A. The mission of the Department shall be to improve the quality of life for older Virginians and to act as a focal point among state agencies for research, policy analysis, long-range planning, and education on aging issues. The Department shall also serve as the lead agency in coordinating the work of state agencies on meeting the needs of an aging society. The Department's policies and programs shall be designed to enable older persons to be as independent and self-sufficient as possible. The Department shall promote local participation in programs for older persons, evaluate and monitor the services provided for older Virginians and provide information to the general public. In furtherance of this mission, the Department shall have, without limitation, the following duties to:

1. Study the economic and physical condition of the residents in the Commonwealth whose age qualifies them for coverage under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, and the employment, medical, educational, recreational and housing facilities available to them, with the view of determining the needs and problems of such persons;

2. Determine the services and facilities, private and governmental and state and local, provided for and available to older persons and to recommend to the appropriate persons such coordination of and changes in such services and facilities as will make them of greater benefit to older persons and more responsive to their needs;

3. Act as the single state agency, under Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States, and as the sole agency for administering or supervising the administration of such plans as may be adopted in accordance with the provisions of such laws. The Department may prepare, submit and carry out state plans and shall be the agency primarily responsible for coordinating state programs and activities related to the purposes of, or undertaken under, such plans or laws;

4. Apply, with the approval of the Governor, for and expend such grants, gifts or bequests from any source that becomes available in connection with its duties under this section, and may comply with such conditions and requirements as may be imposed in connection therewith;

5. Hold hearings and conduct investigations necessary to pass upon applications for approval of a project under the plans and laws set out in subdivision 3, and shall make reports to the Secretary of the United States Department of Health and Human Services as may be required;

6. Designate area agencies on aging pursuant to Public Law 89-73 or any law amendatory or supplemental thereto of the Congress of the United States and to adopt regulations for the composition and operation of such area agencies on aging;

7. Provide information to consumers and their representatives concerning the recognized features of special care units. Such information shall educate consumers and their representatives on how to choose special care and may include brochures and electronic bulletin board notices;

8. Provide staff support to the Commonwealth Council on Aging;

9. Assist state, local, and nonprofit agencies, including, but not limited to, area agencies on aging, in identifying grant and public-private partnership opportunities for improving services to elderly Virginians;

10. Contract with a not-for-profit Virginia corporation granted tax-exempt status under § 501 (c) (3) of the Internal Revenue Code with statewide experience in Virginia in conducting a state long-term care

ombudsman program or designated area agencies on aging for the administration of the ombudsman program. *Such contract shall provide a minimum staffing ratio of one ombudsman to every 2,000 long-term care beds, subject to sufficient appropriations by the General Assembly.* The Department may also contract with such entities for the administration of elder rights programs as authorized under Public Law 89-73, such as insurance counseling and assistance, and to create an elder information/elder rights center;

11. Serve as the focal point for the rights of older Virginians and their families by establishing, maintaining and publicizing a toll-free number to provide resource and referral information, and to provide such other assistance and advice as may be requested; and

12. Develop and maintain a four-year plan for aging services in the Commonwealth, including but not limited to identifying collaborative opportunities with other state and local agencies and programs to better serve the needs of an aging society. This plan shall be developed by the Department in consultation with relevant stakeholders.

B. The governing body of any county, city or town may appropriate funds for support of area agencies on aging designated pursuant to subdivision A 6.

C. All agencies of the Commonwealth shall assist the Department in effectuating its functions in accordance with its designation as the single state agency as required in subdivision A 3.

D. As used in this chapter, "older Virginians" or "older persons" mean persons aged 60 years or older.

§ 54.1-2503. Boards within Department.

In addition to the Board of Health Professions, the following boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Funeral Directors and Embalmers, *Board of Long-Term Care Administrators*, Board of Medicine, Board of Nursing, ~~Board of Nursing Home Administrators~~, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, Board of Social Work and Board of Veterinary Medicine.

§ 54.1-3005. Specific powers and duties of Board.

In addition to the general powers and duties conferred in this title, the Board shall have the following specific powers and duties:

1. To prescribe minimum standards and approve curricula for educational programs preparing persons for licensure or certification under this chapter;

2. To approve programs that meet the requirements of this chapter and of the Board;

3. To provide consultation service for educational programs as requested;

4. To provide for periodic surveys of educational programs;

5. To deny or withdraw approval from educational programs for failure to meet prescribed standards;

6. To provide consultation regarding nursing practice for institutions and agencies as requested and investigate illegal nursing practices;

7. To keep a record of all its proceedings;

8. To certify and maintain a registry of all certified nurse aides and to promulgate regulations consistent with federal law and regulation. The Board shall require all schools to demonstrate their compliance with § 54.1-3006.2 upon application for approval or reapproval, during an on-site visit, or in response to a complaint or a report of noncompliance. The Board may impose a fee pursuant to § 54.1-2401 for any violation thereof. Such regulations may include standards for the authority of licensed practical nurses to teach nurse aides;

9. To approve programs that entitle professional nurses to be registered as clinical nurse specialists and to prescribe minimum standards for such programs;

10. To maintain a registry of clinical nurse specialists and to promulgate regulations governing clinical nurse specialists;

11. To certify and maintain a registry of all certified massage therapists and to promulgate regulations governing the criteria for certification as a massage therapist and the standards of professional conduct for certified massage therapists;

12. To promulgate regulations for the delegation of certain nursing tasks and procedures not involving assessment, evaluation or nursing judgment to an appropriately trained unlicensed person by and under the supervision of a registered nurse, who retains responsibility and accountability for such delegation;

13. To develop and revise as may be necessary, in coordination with the Boards of Medicine and Education, guidelines for the training of employees of a school board in the administration of insulin and glucagon for the purpose of assisting with routine insulin injections and providing emergency treatment for life-threatening hypoglycemia. The first set of such guidelines shall be finalized by September 1, 1999, and shall be made available to local school boards for a fee not to exceed the costs of publication;

14. To enter into the Nurse Licensure Compact as set forth in this chapter and to promulgate regulations for its implementation; ~~and~~

15. To collect, store and make available nursing workforce information regarding the various

categories of nurses certified, licensed or registered pursuant to § 54.1-3012.1;

16. To register medication aides and promulgate regulations governing the criteria for such registration and standards of conduct for medication aides; and

17. To approve training programs for medication aides to include requirements for instructional personnel, curriculum, continuing education, and a competency evaluation.

§ 54.1-3007. Refusal, revocation or suspension, censure or probation.

The Board may refuse to admit a candidate to any examination, refuse to issue a license or certificate, or registration to any applicant and may suspend any license, certificate, registration, or multistate licensure privilege for a stated period or indefinitely, or revoke any license, certificate, registration, or multistate licensure privilege, or censure or reprimand any licensee, certificate holder, registrant, or multistate licensure privilege holder, or place him on probation for such time as it may designate for any of the following causes:

1. Fraud or deceit in procuring or attempting to procure a license, certificate, or registration;
2. Unprofessional conduct;
3. Willful or repeated violation of any of the provisions of this chapter;
4. Conviction of any felony or any misdemeanor involving moral turpitude;
5. Practicing in a manner contrary to the standards of ethics or in such a manner as to make his practice a danger to the health and welfare of patients or to the public;
6. Use of alcohol or drugs to the extent that such use renders him unsafe to practice, or any mental or physical illness rendering him unsafe to practice;
7. The denial, revocation, suspension or restriction of a license, certificate, registration, or multistate licensure privilege to practice in another state, the District of Columbia or a United States possession or territory; or
8. Abuse, negligent practice, or misappropriation of a patient's or resident's property.

Article 7.

Medication Aides.

§ 54.1-3041. Registration required.

A medication aide who administers drugs that would otherwise be self-administered to residents in an assisted living facility licensed by the Department of Social Services shall be registered by the Board.

§ 54.1-3042. Application for registration by competency evaluation.

Every applicant for registration as a medication aide by competency evaluation shall pay the required application fee and shall submit written evidence that the applicant:

1. Has not committed any act that would be grounds for discipline or denial of registration under this article; and
2. Has met the criteria for registration including successful completion of an education or training program approved by the Board.

§ 54.1-3043. Continuing training required.

Every applicant for registration as a medication aide shall complete ongoing training related to the administration of medications as required by the Board.

CHAPTER 31.

NURSING HOME AND ASSISTED LIVING FACILITY ADMINISTRATORS.

§ 54.1-3100. Definitions.

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

"Assisted living facility" means any public or private assisted living facility, as defined in § 63.2-100, that is required to be licensed as an assisted living facility by the Department of Social Services under the provisions of Subtitle IV (§ 63.2-1700 et seq.) of Title 63.2.

"Assisted living facility administrator" means any individual charged with the general administration of an assisted living facility, regardless of whether he has an ownership interest in the facility.

"Board" means the Board of Nursing Home Long-Term Care Administrators.

"Nursing home" means any public or private facility required to be licensed as a nursing home under the provisions of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 and the regulations of the Board of Health.

"Nursing home administrator" means any individual charged with the general administration of a nursing home regardless of whether he has an ownership interest in the facility.

§ 54.1-3101. Board of Long-Term Care Administrators; terms; officers; quorum; special meetings.

The Board of Long-Term Care Administrators is established as a policy board, within the meaning of § 2.2-2100, in the executive branch of state government. The Board of Nursing Home Long-Term Care Administrators shall consist of ~~seven members~~, ~~four~~ nine nonlegislative citizen members to be appointed by the Governor. Nonlegislative citizen members shall be appointed as follows: three who are licensed nursing home administrators; three who are assisted living facility administrators; two who are from professions and institutions concerned with the care and treatment of chronically ill and elderly or mentally impaired patients; or residents; and one who is a resident of a nursing home or assisted living facility or a family member or guardian of a resident of a nursing home or assisted living facility. ~~Two~~ One of the licensed nursing home administrators shall be ~~an administrator~~ an administrator of a proprietary nursing ~~home~~ home. Nonlegislative citizen members of the Board shall be citizens of the

Commonwealth.

After the initial staggering of terms, the terms of Board members shall be four years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed consistent with § 54.1-107.

The Board shall annually elect a chairman *and vice chairman from among its membership.* ~~Four~~ Five members of the Board, including one who is not a licensed nursing home administrator *or assisted living facility administrator*, shall constitute a quorum. Special meetings of the Board shall be called by the chairman upon the written request of any three members.

All members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825. Funding for the costs of expenses shall be provided by the Department of Health Professions.

The Department of Health Professions shall provide staff support to the Board. All agencies of the Commonwealth shall provide assistance to the Board, upon request.

The Board shall be authorized to promulgate canons of ethics under which the professional activities of persons regulated shall be conducted.

§ 54.1-3102. License required.

A. In order to engage in the general administration of a nursing home, it shall be necessary to hold a nursing home administrator's license issued by the Board.

B. *In order to engage in the general administration of an assisted living facility, it shall be necessary to hold an assisted living facility administrator's license or a nursing home administrator's license issued by the Board. However, an administrator of an assisted living facility licensed only to provide residential living care, as defined in § 63.2-100, shall not be required to be licensed.*

§ 54.1-3103. Administrator required for operation of nursing home; operation after death, illness, etc., of administrator; notification of Board.

All licensed nursing homes within the Commonwealth shall be under the supervision of an administrator licensed by the Board. If a licensed nursing home administrator dies, becomes ill, resigns or is discharged, the nursing home ~~which~~ *that* was administered by him at the time of his death, illness, resignation or discharge may continue to operate until his successor qualifies, but in no case for longer than ~~six months~~ *is permitted by the licensing authority for the nursing home.* The temporary supervisor or administrator shall immediately notify the Board of ~~Nursing Home~~ *Long-Term Care* Administrators and the Commissioner of Health that the nursing home is operating without the supervision of a licensed nursing home administrator.

§ 54.1-3103.1. Administrator required for operation of assisted living facility; operation after death, illness, etc., of administrator; notification of Board; administrators operating more than one facility.

A. *All licensed assisted living facilities within the Commonwealth shall be under the supervision of an administrator licensed by the Board, except as provided in subsection B of § 54.1-3102. If a licensed assisted living facility administrator dies, becomes ill, resigns, or is discharged, the assisted living facility that was administered by him at the time of his death, illness, resignation, or discharge may continue to operate until his successor qualifies, but in no case for longer than is permitted by the licensing authority for the facility. The temporary supervisor or administrator shall immediately notify the Board of Long-Term Care Administrators and the Commissioner of the Department of Social Services that the assisted living facility is operating without the supervision of a licensed assisted living facility administrator.*

B. *Nothing in this chapter shall prohibit an assisted living administrator from serving as the administrator of record for more than one assisted living facility as permitted by regulations of the licensing authority for the facility.*

§ 54.1-3408. Professional use by practitioners.

A. A practitioner of medicine, osteopathy, podiatry, dentistry, or veterinary medicine or a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title shall only prescribe, dispense, or administer controlled substances in good faith for medicinal or therapeutic purposes within the course of his professional practice.

B. The prescribing practitioner's order may be on a written prescription or pursuant to an oral prescription as authorized by this chapter. The prescriber may administer drugs and devices, or he may cause them to be administered by a nurse, physician assistant or intern under his direction and supervision, or he may prescribe and cause drugs and devices to be administered to patients in state-owned or state-operated hospitals or facilities licensed as hospitals by the Board of Health or psychiatric hospitals licensed by the State Mental Health, Mental Retardation and Substance Abuse Services Board by other persons who have been trained properly to administer drugs and who administer drugs only under the control and supervision of the prescriber or a pharmacist or a prescriber may cause drugs and devices to be administered to patients by emergency medical services personnel who have been certified and authorized to administer such drugs and devices pursuant to Board of Health regulations governing emergency medical services and who are acting within the scope of such

certification. A prescriber may authorize a certified respiratory therapy practitioner as defined in § 54.1-2954 to administer by inhalation controlled substances used in inhalation or respiratory therapy.

C. Pursuant to an oral or written order or standing protocol, the prescriber, who is authorized by state or federal law to possess and administer radiopharmaceuticals in the scope of his practice, may authorize a nuclear medicine technologist to administer, under his supervision, radiopharmaceuticals used in the diagnosis or treatment of disease.

D. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize registered nurses and licensed practical nurses to possess (i) epinephrine for administration in treatment of emergency medical conditions and (ii) heparin and sterile normal saline to use for the maintenance of intravenous access lines.

Pursuant to the regulations of the Board of Health, certain emergency medical services technicians may possess and administer epinephrine in emergency cases of anaphylactic shock.

E. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize licensed physical therapists to possess and administer topical corticosteroids, topical lidocaine, and any other Schedule VI topical drug.

F. Pursuant to an oral or written order or standing protocol issued by the prescriber within the course of his professional practice, and in accordance with policies and guidelines established by the Department of Health pursuant to § 32.1-50.2, such prescriber may authorize registered nurses or licensed practical nurses under the immediate and direct supervision of a registered nurse to possess and administer tuberculin purified protein derivative (PPD) in the absence of a prescriber. The Department of Health's policies and guidelines shall be consistent with applicable guidelines developed by the Centers for Disease Control and Prevention for preventing transmission of mycobacterium tuberculosis and shall be updated to incorporate any subsequently implemented standards of the Occupational Safety and Health Administration and the Department of Labor and Industry to the extent that they are inconsistent with the Department of Health's policies and guidelines. Such standing protocols shall explicitly describe the categories of persons to whom the tuberculin test is to be administered and shall provide for appropriate medical evaluation of those in whom the test is positive. The prescriber shall ensure that the nurse implementing such standing protocols has received adequate training in the practice and principles underlying tuberculin screening.

The Health Commissioner or his designee may authorize registered nurses, acting as agents of the Department of Health, to possess and administer, at the nurse's discretion, tuberculin purified protein derivative (PPD) to those persons in whom tuberculin skin testing is indicated based on protocols and policies established by the Department of Health.

G. Pursuant to a written order or standing protocol issued by the prescriber within the course of his professional practice, such prescriber may authorize, with the consent of the parents as defined in § 22.1-1, an employee of a school board who is trained in the administration of insulin and glucagon to assist with the administration of insulin or administer glucagon to a student diagnosed as having diabetes and who requires insulin injections during the school day or for whom glucagon has been prescribed for the emergency treatment of hypoglycemia. Such authorization shall only be effective when a licensed nurse, nurse practitioner, physician or physician assistant is not present to perform the administration of the medication.

H. A prescriber may authorize, pursuant to a protocol approved by the Board of Nursing, the administration of vaccines to adults for immunization, when a practitioner with prescriptive authority is not physically present, (i) by licensed pharmacists, (ii) by registered nurses, or (iii) licensed practical nurses under the immediate and direct supervision of a registered nurse. A prescriber acting on behalf of and in accordance with established protocols of the Department of Health may authorize the administration of vaccines to any person by a pharmacist or nurse when the prescriber is not physically present.

I. A dentist may cause Schedule VI topical drugs to be administered under his direction and supervision by either a dental hygienist or by an authorized agent of the dentist.

Further, pursuant to a written order and in accordance with a standing protocol issued by the dentist in the course of his professional practice, a dentist may authorize a dental hygienist under his general supervision, as defined in § 54.1-2722, to possess and administer topical oral fluorides, topical oral anesthetics, topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions, as well as any other Schedule VI topical drug approved by the Board of Dentistry.

J. This section shall not prevent the administration of drugs by a person who has satisfactorily completed a training program for this purpose approved by the Board of Nursing and who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration, and in accordance with regulations promulgated by the Board of Pharmacy relating to security and record keeping, when the drugs administered would be normally self-administered by (i) a resident of a facility licensed or certified by the *State Department of Mental Health, Mental Retardation and Substance Abuse Services Board*; (ii) a resident of any assisted living facility which is licensed by the *Department of Social Services*; (iii) a resident of the Virginia Rehabilitation Center for the Blind and Vision Impaired; ~~(iv)~~ (iii) a resident of a facility approved by the Board or Department of Juvenile

Justice for the placement of children in need of services or delinquent or alleged delinquent youth; ~~(v)~~ (iv) a program participant of an adult day-care center licensed by the Department of Social Services; or ~~(vi)~~ (v) a resident of any facility authorized or operated by a state or local government whose primary purpose is not to provide health care services.

K. *Medication aides registered by the Board of Nursing pursuant to Article 7 (§ 54.1-3041 et seq.) of Chapter 30 may administer drugs that would otherwise be self-administered to residents of any assisted living facility licensed by the Department of Social Services. A registered medication aide shall administer drugs pursuant to this section in accordance with the prescriber's instructions pertaining to dosage, frequency, and manner of administration; in accordance with regulations promulgated by the Board of Pharmacy relating to security and recordkeeping; in accordance with the assisted living facility's Medication Management Plan; and in accordance with such other regulations governing their practice promulgated by the Board of Nursing.*

L. In addition, this section shall not prevent the administration of drugs by a person who administers such drugs in accordance with a physician's instructions pertaining to dosage, frequency, and manner of administration and with written authorization of a parent, and in accordance with school board regulations relating to training, security and record keeping, when the drugs administered would be normally self-administered by a student of a Virginia public school. Training for such persons shall be accomplished through a program approved by the local school boards, in consultation with the local departments of health.

M. In addition, this section shall not prevent the administration or dispensing of drugs and devices by persons if they are authorized by the State Health Commissioner in accordance with protocols established by the State Health Commissioner pursuant to § 32.1-42.1 when (i) the Governor has declared a disaster or a state of emergency caused by an act of terrorism or the United States Secretary of Health and Human Services has issued a declaration of an actual or potential bioterrorism incident or other actual or potential public health emergency; (ii) it is necessary to permit the provision of needed drugs or devices; and (iii) such persons have received the training necessary to safely administer or dispense the needed drugs or devices. Such persons shall administer or dispense all drugs or devices under the direction, control and supervision of the State Health Commissioner.

N. Nothing in this title shall prohibit the administration of normally self-administered oral or topical drugs by unlicensed individuals to a person in his private residence.

O. This section shall not interfere with any prescriber issuing prescriptions in compliance with his authority and scope of practice and the provisions of this section to a Board agent for use pursuant to subsection G of § 18.2-258.1. Such prescriptions issued by such prescriber shall be deemed to be valid prescriptions.

P. Nothing in this title shall prevent or interfere with dialysis care technicians or dialysis patient care technicians who are certified by an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.) of this title, in the ordinary course of their duties in a Medicare-certified renal dialysis facility, from administering heparin, topical needle site anesthetics, dialysis solutions, sterile normal saline solution, and blood volumizers, for the purpose of facilitating renal dialysis treatment, when such administration of medications occurs under the orders of a licensed physician, nurse practitioner or physician assistant and under the immediate and direct supervision of a licensed registered nurse.

The dialysis care technician or dialysis patient care technician administering the medications shall have demonstrated competency as evidenced by holding current valid certification from an organization approved by the Board of Health Professions pursuant to Chapter 27.01 (§ 54.1-2729.1 et seq.) of this title.

§ 63.2-1702. Investigation on receipt of application.

Upon receipt of the application the Commissioner shall cause an investigation to be made of the activities, services and facilities of the applicant, of the applicant's financial responsibility, and of his character and reputation or, if the applicant is an association, partnership, limited liability company or corporation, the character and reputation of its officers and agents. In the case of child welfare agencies, the financial records of an applicant shall not be subject to inspection if the applicant submits a current balance sheet and income statement accompanied by a letter from a certified public accountant certifying the accuracy thereof and three credit references. In the case of child welfare agencies *and assisted living facilities*, the character and reputation investigation upon application shall include background checks pursuant to § 63.2-1721; however, a children's residential facility shall comply with the background check requirements contained in § 63.2-1726.

§ 63.2-1707. Issuance or refusal of license; notification; provisional and conditional licenses.

Upon completion of his investigation, the Commissioner shall issue an appropriate license to the applicant if (i) the applicant has made adequate provision for such activities, services and facilities as are reasonably conducive to the welfare of the residents, participants or children over whom he may have custody or control; (ii) the applicant has submitted satisfactory documentation of financial responsibility such as, but not limited to, a letter of credit, a certified financial statement, or similar documents; (iii) he is, or the officers and agents of the applicant if it is an association, partnership,

limited liability company or corporation are, of good character and reputation; and (iv) the applicant and agents comply with the provisions of this subtitle. Otherwise, the license shall be denied. Immediately upon taking final action, the Commissioner shall notify the applicant of such action.

Upon completion of the investigation for the renewal of a license, the Commissioner may issue a provisional license to any applicant if the applicant is temporarily unable to comply with all of the licensure requirements. ~~Such~~ *The* provisional license may be renewed, but the issuance of a provisional license and any renewals thereof shall be for no longer a period than six successive months. *A copy of the provisional license shall be prominently displayed by the provider at each public entrance of the subject facility and shall be printed in a clear and legible size and style. In addition, the facility shall be required to prominently display next to the posted provisional license a notice that a description of specific violations of licensing standards to be corrected and the deadline for completion of such corrections is available for inspection at the facility and on the facility's website, if applicable.*

At the discretion of the Commissioner, a conditional license may be issued to an applicant to operate a new facility in order to permit the applicant to demonstrate compliance with licensure requirements. Such conditional license may be renewed, but the issuance of a conditional license and any renewals thereof shall be for no longer a period than six successive months.

§ 63.2-1709. Enforcement and sanctions; assisted living facilities and adult day care centers; interim administration; receivership, revocation, denial, summary suspension.

A. Upon receipt and verification by the Commissioner of information from any source indicating an imminent and substantial risk of harm to residents, the Commissioner may require an assisted living facility to contract with an individual licensed by the Board of Long-Term Care Administrators, to be either selected from a list created and maintained by the Department of Medical Assistance Services or selected from a pool of appropriately licensed administrators recommended by the owner of the assisted living facility, to administer, manage, or operate the assisted living facility on an interim basis, and to attempt to bring the facility into compliance with all relevant requirements of law, regulation, or any plan of correction approved by the Commissioner. Such contract shall require the interim administrator to comply with any and all requirements established by the Department to ensure the health, safety, and welfare of the residents. Prior to or upon conclusion of the period of interim administration, management, or operation, an inspection shall be conducted to determine whether operation of the assisted living facility shall be permitted to continue or should cease. Such interim administration, management, or operation shall not be permitted when defects in the conditions of the premises of the assisted living facility (i) present imminent and substantial risks to the health, safety, and welfare of residents, and (ii) may not be corrected within a reasonable period of time. Any decision by the Commissioner to require the employment of a person to administer, manage, or operate an assisted living facility shall be subject to the rights of judicial review and appeal as provided in the Administrative Process Act (§ 2.2-4000 et seq.). Actual and reasonable costs of such interim administration shall be the responsibility of and shall be borne by the owner of the assisted living facility.

B. The Board shall adopt regulations for the Commissioner to use in determining when the imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is appropriate in order to ensure prompt correction of violations in assisted living facilities and adult day care centers involving noncompliance with state law or regulation as discovered through any inspection or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental Retardation and Substance Abuse Services. The Commissioner may impose such sanctions or take such actions as are appropriate for violation of any of the provisions of this subtitle or any regulation adopted under any provision of this subtitle that adversely affects the health, safety or welfare of an assisted living facility resident or an adult day care participant. Such sanctions or actions may include (i) petitioning the court to appoint a receiver for any assisted living facility or adult day care center and (ii) revoking or denying renewal of the license for the assisted living facility or adult day care center for violation of any of the provisions of this subtitle, § 54.1-3408 or any regulation adopted under this subtitle that violation adversely affects, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding or abetting the commission of any illegal act in an assisted living facility or adult day care center.

C. The Commissioner may issue a summary order of suspension of the license to operate the assisted living facility pursuant to the procedures hereinafter set forth in conjunction with any proceeding for revocation, denial, or other action when conditions or practices exist that pose an imminent and substantial threat to the health, safety, and welfare of the residents. Before a summary order of suspension shall take effect, the Commissioner shall issue to the assisted living facility a notice of summary order of suspension setting forth (i) the procedures for the summary order of suspension, (ii) hearing and appeal rights as provided under this subsection, and (iii) facts and evidence that formed the basis for which the summary order of suspension is sought. Such notice shall be served on the assisted living facility or its designee as soon as practicable thereafter by personal service or certified mail, return receipt requested, to the address of record of the assisted living facility. The order shall state the time, date, and location of a hearing to determine whether the suspension is appropriate. Such hearing

shall be presided over by a hearing officer selected by the Commissioner from a list prepared by the Executive Secretary of the Supreme Court of Virginia and shall be held as soon as practicable, but in no event later than 15 business days following service of the notice of hearing; however, the hearing officer may grant a written request for a continuance, not to exceed an additional 10 business days, for good cause shown. After such hearing, the hearing officer shall provide to the Commissioner written findings and conclusions, together with a recommendation whether the license should be summarily suspended, whereupon the Commissioner shall adopt the hearing officer's recommended decision unless to do so would be an error of law or Department policy. Any final agency case decision in which the Commissioner rejects a hearing officer's recommended decision shall state with particularity the basis for rejection. The Commissioner shall issue: (a) a final order of summary suspension or (b) an order that summary suspension is not warranted by the facts and circumstances presented. A final order of summary suspension shall include notice that the assisted living facility may appeal the Commissioner's decision to the appropriate circuit court no later than 10 days following service of the order. A copy of any final order of summary suspension shall be prominently displayed by the provider at each public entrance of the facility, or in lieu thereof, the provider may display a written statement summarizing the terms of the order in a prominent location, printed in a clear and legible size and typeface, and identifying the location within the facility where the final order of summary suspension may be reviewed.

Upon appeal, the sole issue before the court shall be whether the Department had reasonable grounds to require the assisted living facility to cease operations during the pendency of the concurrent revocation, denial, or other proceeding. Any concurrent revocation, denial, or other proceeding shall not be affected by the outcome of any hearing on the appropriateness of the summary order of suspension. Failure to comply with the summary order of suspension shall constitute an offense under subdivision 1 of § 63.2-1712. All agencies and subdivisions of the Commonwealth shall cooperate with the Commissioner in the relocation of residents of an assisted living facility whose license has been summarily suspended pursuant to this section and in any other actions necessary to reduce the risk of further harm to residents.

D. Notice of the Commissioner's intent to revoke or deny renewal of the license for the assisted living facility shall be provided by the Department and a copy of such notice shall be posted in a prominent place at each public entrance of the licensed premises to advise consumers of serious or persistent violations. In determining whether to deny, revoke, or summarily suspend a license, the Commissioner may choose to deny, revoke, or summarily suspend only certain authority of the assisted living facility to operate, and may restrict or modify the assisted living facility's authority to provide certain services or perform certain functions that the Commissioner determines should be restricted or modified in order to protect the health, safety, or welfare of the residents. Such denial, revocation, or summary suspension of certain services or functions may be appealed as otherwise provided in this subtitle for any denial, revocation, or summary suspension.

B. The Commissioner may revoke or deny the renewal of the license of any child welfare agency which violates any provision of this subtitle or fails to comply with the limitations and standards set forth in its license.

C. Notwithstanding any other provision of law, following a proceeding as provided in § 2.2-4019, the Commissioner may issue a special order for violation of any of the provisions of this subtitle, § 54.1-3408 or any regulation adopted under any provision of this subtitle that violation adversely affects, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for therein, or for permitting, aiding or abetting the commission of any illegal act in an assisted living facility, adult day care center or child welfare agency. The issuance of a special order shall be considered a case decision as defined in § 2.2-4001. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders.

D. The Commissioner may take the following actions regarding licensed assisted living facilities, adult day care centers and child welfare agencies through the issuance of a special order:

1. Place a licensee on probation upon finding that the licensee is substantially out of compliance with the terms of its license and that the health and safety of residents, participants or children are at risk;
2. Reduce licensed capacity or prohibit new admissions when the Commissioner concludes that the licensee cannot make necessary corrections to achieve compliance with regulations except by a temporary restriction of its scope of service;
3. Require that probationary status announcements, provisional licenses, and denial or revocation notices be posted in a prominent place at each public entrance of the licensed premises and be of sufficient size and distinction to advise consumers of serious or persistent violations;
4. Mandate training for the licensee or licensee's employees, with any costs to be borne by the licensee, when the Commissioner concludes that the lack of such training has led directly to violations of regulations;
5. Assess civil penalties of not more than \$500 per inspection upon finding that the licensee is substantially out of compliance with the terms of its license and the health and safety of residents, participants or children are at risk;

6. Require licensees to contact parents, guardians or other responsible persons in writing regarding health and safety violations; and

7. Prevent licensees who are substantially out of compliance with the licensure terms or in violation of the regulations from receiving public funds.

~~E. The Board shall adopt regulations to implement the provisions of this section.~~

§ 63.2-1709.1. Enforcement and sanctions; child welfare agencies; revocation and denial.

The Commissioner may revoke or deny the renewal of the license of any child welfare agency that violates any provision of this subtitle or fails to comply with the limitations and standards set forth in its license.

§ 63.2-1709.2. Enforcement and sanctions; special orders; civil penalties.

A. Notwithstanding any other provision of law, following a proceeding as provided in § 2.2-4019, the Commissioner may issue a special order (i) for violation of any of the provisions of this subtitle, § 54.1-3408, or any regulation adopted under any provision of this subtitle which violation adversely affects, or is an imminent and substantial threat to, the health, safety, or welfare of the person cared for therein, or (ii) for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility, adult day care center, or child welfare agency. Notice of the Commissioner's intent to take any of the actions enumerated in subdivisions B 1 through B 7 shall be provided by the Department and a copy of such notice shall be posted in a prominent place at each public entrance of the licensed premises to advise consumers of serious or persistent violations. The issuance of a special order shall be considered a case decision as defined in § 2.2-4001. The Commissioner shall not delegate his authority to impose civil penalties in conjunction with the issuance of special orders.

B. The Commissioner may take the following actions regarding assisted living facilities, adult day care centers, and child welfare agencies through the issuance of a special order and may require a copy of the special order provided by the Department to be posted in a prominent place at each public entrance of the licensed premises to advise consumers of serious or persistent violations:

1. Place a licensee on probation upon finding that the licensee is substantially out of compliance with the terms of its license and that the health and safety of residents, participants, or children are at risk;

2. Reduce licensed capacity or prohibit new admissions when the Commissioner concludes that the licensee cannot make necessary corrections to achieve compliance with regulations except by a temporary restriction of its scope of service;

3. Mandate training for the licensee or licensee's employees, with any costs to be borne by the licensee, when the Commissioner concludes that the lack of such training has led directly to violations of regulations;

4. Assess civil penalties for each day the assisted living facility is or was out of compliance with the terms of its license and the health, safety, and welfare of residents are at risk, which shall be paid into the state treasury and credited to the Assisted Living Facility Education, Training, and Technical Assistance Fund created pursuant to § 63.2-1803.1. The aggregate amount of such civil penalties shall not exceed \$10,000 for assisted living facilities in any 24-month period. Criteria for imposition of civil penalties and amounts, expressed in ranges, shall be developed by the Board, and shall be based upon the severity, pervasiveness, duration, and degree of risk to the health, safety, or welfare of residents. Such civil penalties shall be applied by the Commissioner in a consistent manner. Such criteria shall also provide that (i) the Commissioner may accept a plan of correction, including a schedule of compliance, from an assisted living facility prior to setting a civil penalty, and (ii) the Commissioner may reduce or abate the penalty amount if the facility complies with the plan of correction within its terms.

A single act, omission, or incident shall not give rise to imposition of multiple civil penalties even though such act, omission, or incident may violate more than one statute or regulation. A civil penalty that is not appealed becomes due on the first day after the appeal period expires. The license of an assisted living facility that has failed to pay a civil penalty due under this section shall not be renewed until the civil penalty has been paid in full, with interest, provided that the Commissioner may renew a license when an unpaid civil penalty is the subject of a pending appeal;

5. Assess civil penalties of not more than \$500 per inspection upon finding that the adult day care center or child welfare agency is substantially out of compliance with the terms of its license and the health and safety of residents, participants, or children are at risk;

6. Require licensees to contact parents, guardians, or other responsible persons in writing regarding health and safety violations; and

7. Prevent licensees who are substantially out of compliance with the licensure terms or in violation of the regulations from receiving public funds.

~~C. The Board shall adopt regulations to implement the provisions of this section.~~

§ 63.2-1721. Background check upon application for licensure or registration; background check of foster or adoptive parents approved by child-placing agencies and family day homes approved by family day systems; penalty.

A. Upon application for licensure or registration as a child welfare agency, (i) all applicants; (ii)

agents at the time of application who are or will be involved in the day-to-day operations of the child welfare agency or who are or will be alone with, in control of, or supervising one or more of the children; and (iii) any other adult living in the home of an applicant for licensure or registration as a family day home shall undergo a background check. *Upon application for licensure as an assisted living facility, all applicants shall undergo a background check.* In addition, foster or adoptive parents requesting approval by child-placing agencies and operators of family day homes requesting approval by family day systems, and any other adult residing in the family day home or existing employee or volunteer of the family day home, shall undergo background checks pursuant to subsection B prior to their approval.

B. Background checks pursuant to this section require:

1. A sworn statement or affirmation disclosing whether the person has a criminal conviction or is the subject of any pending criminal charges within or outside the Commonwealth and whether or not the person has been the subject of a founded complaint of child abuse or neglect within or outside the Commonwealth;

2. A criminal history record check through the Central Criminal Records Exchange pursuant to § 19.2-389; and

3. *A In the case of child welfare agencies or adoptive or foster parents, a search of the central registry maintained pursuant to § 63.2-1515 for any founded complaint of child abuse and neglect.*

C. The character and reputation investigation pursuant to § 63.2-1702 shall include background checks pursuant to subsection B of persons specified in subsection A. The applicant shall submit the background check information required in subsection B to the Commissioner's representative prior to issuance of a license, registration or approval. The applicant shall provide an original criminal record clearance with respect to offenses specified in § 63.2-1719 or an original criminal history record from the Central Criminal Records Exchange. Any person making a materially false statement regarding the sworn statement or affirmation provided pursuant to subdivision B 1 shall be guilty of a Class 1 misdemeanor. If any person specified in subsection A required to have a background check has any offense as defined in § 63.2-1719, and such person has not been granted a waiver by the Commissioner pursuant to § 63.2-1723 or is not subject to an exception in subsections E or F, (i) the Commissioner shall not issue a license or registration to a child welfare agency; (ii) *the Commissioner shall not issue a license to an assisted living facility;* (iii) a child-placing agency shall not approve an adoptive or foster home; or (iii) (iv) a family day system shall not approve a family day home.

D. No person specified in subsection A shall be involved in the day-to-day operations of the child welfare agency or shall be alone with, in control of, or supervising one or more of the children without first having completed background checks pursuant to subsection B.

E. Notwithstanding any provision to the contrary contained in this section, a child-placing agency may approve as an adoptive parent an applicant convicted of not more than one misdemeanor as set out in § 18.2-57 not involving abuse, neglect or moral turpitude, provided 10 years have elapsed following the conviction.

F. Notwithstanding any provision to the contrary contained in this section, a child-placing agency may approve as a foster parent an applicant convicted of statutory burglary for breaking and entering a dwelling home or other structure with intent to commit larceny, who has had his civil rights restored by the Governor, provided 25 years have elapsed following the conviction.

G. If an applicant is denied licensure, registration or approval because of information from the central registry or convictions appearing on his criminal history record, the Commissioner shall provide a copy of the information obtained from the central registry or the Central Criminal Records Exchange or both to the applicant.

H. Further dissemination of the background check information is prohibited other than to the Commissioner's representative or a federal or state authority or court as may be required to comply with an express requirement of law for such further dissemination.

I. The provisions of this section referring to a sworn statement or affirmation and to prohibitions on the issuance of a license for any offense shall not apply to any children's residential facility licensed pursuant to § 63.2-1701, which instead shall comply with the background investigation requirements contained in § 63.2-1726.

§ 63.2-1732. Regulations for assisted living facilities.

A. The Board shall have the authority to adopt and enforce regulations to carry out the provisions of this subtitle and to protect the health, safety, welfare and individual rights of residents of assisted living facilities and to promote their highest level of functioning. Such regulations shall take into consideration cost constraints of smaller operations in complying with such regulations *and shall provide a procedure whereby a licensee or applicant may request, and the Commissioner may grant, an allowable variance to a regulation pursuant to § 63.2-1703.*

B. Regulations shall include standards for staff qualifications and training; facility design, functional design and equipment; services to be provided to residents; administration of medicine; allowable medical conditions for which care can be provided; and medical procedures to be followed by staff, including provisions for physicians' services, restorative care, and specialized rehabilitative services. *The*

Board shall adopt regulations on qualifications and training for employees of an assisted living facility in a direct care position. "Direct care position" means supervisors, assistants, aides, or other employees of a facility who assist residents in their daily living activities.

C. Regulations for a Medication Management Plan in a licensed assisted living facility shall be developed by the Board, in consultation with the Board of Nursing and the Board of Pharmacy. Such regulations shall (i) establish the elements to be contained within a Medication Management Plan, including a demonstrated understanding of the responsibilities associated with medication management by the facility; standard operating and record-keeping procedures; staff qualifications, training and supervision; documentation of daily medication administration; and internal monitoring of plan conformance by the facility; (ii) include a requirement that each assisted living facility shall establish and maintain a written Medication Management Plan that has been approved by the Department; and (iii) provide that a facility's failure to conform to any approved Medication Management Plan shall be subject to the sanctions set forth in § 63.2-1709 or 63.2-1709.2.

Ⓒ D. Regulations shall require all licensed assisted living facilities with six or more residents to be able to connect by July 1, 2007, to a temporary emergency electrical power source for the provision of electricity during an interruption of the normal electric power supply. The installation shall be in compliance with the Uniform Statewide Building Code.

Ⓓ E. Regulations for medical procedures in assisted living facilities shall be developed in consultation with the State Board of Health and adopted by the Board, and compliance with these regulations shall be determined by Department of Health or Department inspectors as provided by an interagency agreement between the Department and the Department of Health.

F. In developing regulations to determine the number of assisted living facilities for which an assisted living administrator may serve as administrator of record, the Board shall consider (i) the number of residents in each of the facilities, (ii) the travel time between each of the facilities, and (iii) the qualifications of the on-site manager under the supervision of the administrator of record.

§ 63.2-1803. Staffing of assisted living facilities.

A. An administrator is ~~any person meeting the qualifications for administrator~~ of an assisted living facility; ~~pursuant to regulations adopted by the Board shall be licensed as an assisted living facility administrator by the Virginia Board of Long-Term Care Administrators pursuant to Chapter 31 (§ 54.1-3100 et seq.) of Title 54.1. However, an administrator of an assisted living facility licensed for residential living care only shall not be required to be licensed.~~ Any person meeting the qualifications for a licensed nursing home administrator under § 54.1-3103 shall be deemed qualified to (i) serve as an administrator of an assisted living facility or (ii) serve as the administrator of both an assisted living facility and a licensed nursing home, provided the assisted living facility and licensed nursing home are part of the same building.

B. The assisted living facility shall have adequate, *appropriate*, and sufficient staff to provide services to attain and maintain (i) the physical, mental and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and (ii) the physical safety of the residents on the premises. Upon admission and upon request, the assisted living facility shall provide in writing a description of the types of staff working in the facility and the services provided, including the hours such services are available.

§ 63.2-1803.1. Assisted Living Facility Education, Training, and Technical Assistance Fund established.

There is hereby created in the state treasury a special nonreverting fund to be known as the Assisted Living Facility Education, Training, and Technical Assistance Fund, hereafter referred to as "the Fund." The Fund shall be established on the books of the Comptroller. All penalties directed to this fund by subdivision B 4 of § 63.2-1709.2 and all other funds from any public or private source directed to the Fund shall be paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purpose of providing education and training for staff of and technical assistance to assisted living facilities to improve the quality of care in such facilities. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner.

§ 63.2-1805. Admission, retention, and discharge.

A. The Board shall adopt regulations:

1. Governing admissions to assisted living facilities;
2. Requiring that each assisted living facility prepare and provide a statement, in a format prescribed by the Department, to any prospective resident and his legal representative, if any, prior to admission and upon request, that discloses information, fully and accurately in plain language, about the (i) services; (ii) fees, including clear information about what services are included in the base fee and any fees for additional services; (iii) admission, transfer, and discharge criteria, including criteria for transfer to another level of care within the same facility or complex; (iv) general number and qualifications of staff on each shift; (v) range, frequency, and number of activities provided for

residents; and (vi) ownership structure of the facility;

3. Establishing a process to ensure that ~~residents~~ *each resident* admitted or retained in an assisted living facility ~~receive the receives~~ appropriate services and ~~that, in order to determine whether a resident's needs can continue to be met by the facility and whether continued placement in the facility is in the best interests of the resident,~~ *each resident receives* periodic independent reassessments and reassessments ~~in the event of when there is a significant deterioration of change in the resident's condition in order to determine whether a resident's needs can continue to be met by the facility and whether continued placement in the facility is in the best interests of the resident;~~

~~3~~ 4. Governing appropriate discharge planning for residents whose care needs can no longer be met by the facility;

4 5. Addressing the involuntary discharge of residents;

5 6. Requiring that residents are informed of their rights pursuant to § 63.2-1808 at the time of admission;

6 7. Establishing a process to ensure that any resident temporarily detained in an inpatient facility pursuant to § 37.1-67.1 is accepted back in the assisted living facility if the resident is not involuntarily committed pursuant to § 37.1-67.3; and

7 8. Requiring that each assisted living facility train all employees who are mandated to report adult abuse, neglect, or exploitation pursuant to § 63.2-1606 on such reporting procedures and the consequences for failing to make a required report.

B. *If there are observed behaviors or patterns of behavior indicative of mental illness, mental retardation, substance abuse, or behavioral disorders, as documented in the uniform assessment instrument completed pursuant to § 63.2-1804, the facility administrator or designated staff member shall ensure that an evaluation of the individual is or has been conducted by a qualified professional as defined in regulations. If the evaluation indicates a need for mental health, mental retardation, substance abuse, or behavioral disorder services, the facility shall provide (i) a notification of the resident's need for such services to the authorized contact person of record when available and (ii) a notification of the resident's need for such services to the community services board or behavioral health authority established pursuant to Title 37.1 that serves the city or county in which the facility is located, or other appropriate licensed provider. The Department shall not take adverse action against a facility that has demonstrated and documented a continual good faith effort to meet the requirements of this subsection.*

C. Assisted living facilities shall not admit or retain ~~individuals~~ *an individual* with any of the following conditions or care needs:

1. Ventilator dependency.

2. Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be healing.

3. Intravenous therapy or injections directly into the vein except for intermittent intravenous therapy managed by a health care professional licensed in Virginia or as permitted in subsection C D.

4. Airborne infectious disease in a communicable state, that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common cold.

5. Psychotropic medications without appropriate diagnosis and treatment plans.

6. Nasogastric tubes.

7. Gastric tubes except when the individual is capable of independently feeding himself and caring for the tube or as permitted in subsection C D.

8. ~~Individuals presenting~~ *An imminent physical threat or danger to self or others is presented by the individual.*

9. ~~Individuals requiring~~ *Continuous licensed nursing care (seven-days-a-week, 24-hours-a-day) is required by the individual.*

10. ~~Individuals whose physician certifies that~~ *Placement is no longer appropriate as certified by the individual's physician.*

11. ~~Unless the individual's independent physician determines otherwise, individuals who require~~ *Maximum physical assistance is required by the individual as documented by the uniform assessment instrument and meet the individual meets* Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance, ~~unless the individual's independent physician determines otherwise.~~ *Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on the uniform assessment instrument.*

12. ~~Individuals whose health care needs cannot be met in the specific~~ *The assisted living facility as determined by the facility determines that it cannot meet the individual's physical or mental health care needs.*

13. ~~Such~~ *Other medical and functional care needs of residents which that* the Board determines cannot ~~properly~~ *properly* be met *properly* in an assisted living facility.

C D. Except for auxiliary grant recipients, at the request of the resident, and pursuant to regulations of the Board, care for the conditions or care needs defined in subdivisions B C 3 and B C 7 may be

provided to a resident in an assisted living facility by a licensed physician, a licensed nurse or a nurse holding a multistate licensure privilege under a physician's treatment plan, or by a home care organization licensed in Virginia when the resident's independent physician determines that such care is appropriate for the resident.

Ð *E.* In adopting regulations pursuant to subsections A, B and, C and D, the Board shall consult with the Departments of Health and Mental Health, Mental Retardation and Substance Abuse Services.

2. That the Board of Nursing shall convene a task force to develop regulations for the registration of medication aides and submit a progress report on such regulations to the chairmen of the Joint Commission on Health Care, the House Committee on Health, Welfare and Institutions and the Senate Committee on Rehabilitation and Social Services on or before December 1, 2005.

3. That the Board of Nursing shall adopt final regulations to implement the provisions of this act to be effective on or before July 1, 2007.

4. That, notwithstanding the due course effective date of this act, the provisions of this act in §§ 54.1-3041, 54.1-3042, 54.1-3043 and 54.1-3408 of the Code of Virginia shall not be implemented or enforced until 12 months after the regulations promulgated pursuant to the third enactment become effective; however, the Board of Nursing may accept and process applications for the registration of medication aides and charge an application fee anytime on or after July 1, 2005.

5. That the Board of Long-Term Care Administrators shall convene a task force to develop licensing regulations for assisted living facility administrators and submit an initial progress report by November 1, 2005, and a follow-up progress report by November 1, 2006, on such regulations to the chairmen of the Joint Commission on Health Care, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Rehabilitation and Social Services.

6. That the Board of Long-Term Care Administrators shall adopt final regulations to implement the provisions of this act to be effective on or before July 1, 2007.

7. That, notwithstanding the due course effective date of this act, the provisions of this act in §§ 54.1-3102, 54.1-3103.1 and 63.2-1803 shall not be implemented or enforced until 12 months after the regulations promulgated pursuant to the sixth enactment become effective.

8. That the State Board of Social Services shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

9. That the Department of Social Services shall submit a report on the implementation of this act to the Governor and the chairmen of the Joint Commission on Health Care, the House Committee on Health, Welfare and Institutions, and the Senate Committee on Rehabilitation and Social Services by November 1, 2005.

10. That the Department of Social Services shall develop a training module on assisted living facilities, including all applicable statutes and regulations, that shall be used to train all adult care licensing inspectors currently employed by the Department no later than October 1, 2005. Any person subsequently employed as an adult care inspector shall receive such training no later than 60 days following the commencement of employment.

11. That the Department of Social Services shall seek consultation and information from all relevant agencies of government in its development of regulations and policies to implement the provisions of the act. The Department of Social Services shall integrate into the regulations and policies standards that are consistent with the recommendations of the Department of Mental Health, Mental Retardation and Substance Abuse Services necessary to ensure appropriate care for residents with mental illness, mental retardation, substance abuse, and other behavioral disabilities. The Department of Mental Health, Mental Retardation and Substance Abuse Services shall cooperate fully in the development of these standards.

12. That the Executive Secretary of the Supreme Court and the Department of Social Services shall establish a protocol for the expedited appointment of a hearing officer to comply with subsection C of § 63.2-1709.

2005 SESSION

INTRODUCED

051353136

HOUSE BILL NO. 2513

Offered January 12, 2005

Prefiled January 12, 2005

A BILL to amend the Code of Virginia by adding in Article 13 of Chapter 3 of Title 58.1 a section numbered 58.1-439.12.1, relating to employer provided long-term care insurance tax credit.

Patrons—Landes, Athey, Brink, Hamilton, Jones, S.C., Morgan, O'Bannon and Sherwood; Senators: Blevins, Houck, Lambert, Martin, Puller and Rerras

Referred to Committee on Finance

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 13 of Chapter 3 of Title 58.1 a section numbered 58.1-439.12.1as follows:

§ 58.1-439.12.1. Tax credit for employer provided long-term care insurance.

A. For taxable years beginning on and after January 1, 2006, a taxpayer who operates a business within the Commonwealth that provides benefits to its employees shall be allowed a credit against the taxes imposed pursuant to Articles 2 (§ 58.1-320 et seq.) and 10 (§ 58.1-400 et seq.) of this chapter in an amount equal to 10 percent of the premium costs incurred during the taxable year to provide long-term care insurance, as defined in § 38.2-5200, as part of an employee benefits package. The total credit allowed to any taxpayer under this section in any taxable year shall not exceed (i) \$5,000 or (ii) \$100 per employee, whichever is less.

B. The taxpayer shall submit with his income tax return such receipts, premium statements, and other documentation as required by the Department of Taxation to confirm the taxpayer's statement of the total amount paid for the employees' long-term care insurance.

C. Any tax credit under this section not usable for the taxable year in which the long-term care insurance premium was paid may be carried over for the next three taxable years. The amount of credit allowed pursuant to this section shall not exceed the tax imposed for any taxable year. No credit shall be carried back to a preceding taxable year.

D. For purposes of this section, the amount of any credit attributable to the purchase of long-term care insurance by a partnership or electing small business corporation (S corporation) shall be allocated to the individual partners or shareholders in proportion to their ownership or interest in the partnership or S corporation.

INTRODUCED

HB2513

1/28/05 10:28

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 111

An Act to repeal Chapter 12 (§§ 37.1-225 through 37.1-233) of Title 37.1 of the Code of Virginia, relating to disclosure of patient information by certain health care providers.

[H 2514]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

1. That Chapter 12 (§§ 37.1-225 through 37.1-233) of Title 37.1 of the Code of Virginia is repealed.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 642

An Act to amend and reenact §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the Code of Virginia, relating to charges for copying health records.

[H 2515]

Approved March 23, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-413. Certain copies of health care provider's records or papers of patient admissible; right of patient, his attorney and authorized insurer to copies of such records or papers; subpoena; damages, costs and attorneys' fees.

A. In any case where the hospital, nursing facility, physician's, or other health care provider's original records or papers of any patient in a hospital or institution for the treatment of physical or mental illness are admissible or would be admissible as evidence, any typewritten copy, photograph, photostatted copy, or microphotograph or printout or other hard copy generated from computerized or other electronic storage, microfilm, or other photographic, mechanical, electronic or chemical storage process thereof shall be admissible as evidence in any court of this Commonwealth in like manner as the original, if the printout or hard copy or microphotograph or photograph is properly authenticated by the employees having authority to release or produce the original records.

Any hospital, nursing facility, physician, or other health care provider whose records or papers relating to any such patient are subpoenaed for production as provided by law may comply with the subpoena by a timely mailing to the clerk issuing the subpoena or in whose court the action is pending properly authenticated copies, photographs or microphotographs in lieu of the originals. The court whose clerk issued the subpoena or, in the case of an attorney-issued subpoena, in which the action is pending, may, after notice to such hospital, nursing facility, physician, or other health care provider, enter an order requiring production of the originals, if available, of any stored records or papers whose copies, photographs or microphotographs are not sufficiently legible.

Except as provided in subsection G, the party requesting the subpoena duces tecum or on whose behalf an attorney-issued subpoena duces tecum was issued shall be liable for the reasonable charges of the hospital, nursing facility, physician, or other health care provider for the service of maintaining, retrieving, reviewing, preparing, copying and mailing the items produced. Except for copies of X-ray photographs, however, such charges shall not exceed ~~\$50~~ \$0.50 for each page up to 50 pages and ~~\$.25~~ \$0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and \$1 per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed \$10.

B. Copies of hospital, nursing facility, physician's, or other health care provider's records or papers shall be furnished within 15 days of receipt of such request to the patient, his attorney, his executor or administrator, or an authorized insurer upon such patient's, attorney's, executor's, administrator's, or authorized insurer's written request, which request shall comply with the requirements of subsection E of § 32.1-127.1:03.

However, copies of a patient's records shall not be furnished to such patient when the patient's treating physician or clinical psychologist, in the exercise of professional judgment, has made a part of the patient's records a written statement that in his opinion the furnishing to or review by the patient of such records would be reasonably likely to endanger the life or physical safety of the patient or another person, or that such health records make reference to a person, other than a health care provider, and the access requested would be reasonably likely to cause substantial harm to such referenced person. In any such case, if requested by the patient or his attorney or authorized insurer, such records shall be furnished within 15 days of the date of such request to the patient's attorney or authorized insurer, rather than to the patient.

If the records are not provided to the patient in accordance with this section, then, if requested by the patient, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the patient's request to either (i) provide a copy of the records to a physician or clinical psychologist of the patient's choice whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating physician or clinical psychologist upon whose opinion the denial is based, who shall, at the patient's expense, make a judgment as to whether to make the records available to the patient or (ii) designate a physician or clinical psychologist, whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating

physician or clinical psychologist upon whose opinion the denial is based and who did not participate in the original decision to deny the patient's request for his records, who shall, at the expense of the provider denying access to the patient, review the records and make a judgment as to whether to make the records available to the patient. In either such event, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the judgment of the reviewing physician or clinical psychologist.

Except as provided in subsection G, a reasonable charge may be made by the hospital, nursing facility, physician or other health care provider maintaining the records for the cost of the services relating to the maintenance, retrieval, review, and preparation of the copies of the records. Except for copies of X-ray photographs, however, such charges shall not exceed ~~\$.50~~ \$0.50 per page for up to 50 pages and ~~\$.25~~ \$0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and \$1 per page for copies from microfilm or other micrographic process, a fee for search and handling, not to exceed \$10, and all postage and shipping costs. Any hospital, nursing facility, physician, or other health care provider receiving such a request from a patient's attorney or authorized insurer shall require a writing signed by the patient confirming the attorney's or authorized insurer's authority to make the request and shall accept a photocopy, facsimile, or other copy of the original signed by the patient as if it were an original.

C. Upon the failure of any hospital, nursing facility, physician, or other health care provider to comply with any written request made in accordance with subsection B within the period of time specified in that subsection and within the manner specified in subsections E and F of § 32.1-127.1:03, the patient, his attorney, his executor or administrator, or authorized insurer may cause a subpoena duces tecum to be issued. The subpoena may be issued (i) upon filing a request therefor with the clerk of the circuit court wherein any eventual suit would be required to be filed, and upon payment of the fees required by subdivision A 18 of § 17.1-275, and fees for service or (ii) by the patient's attorney in a pending civil case in accordance with § 8.01-407 without payment of the fees established in subdivision A 23 of § 17.1-275. A sheriff shall not be required to serve an attorney-issued subpoena that is not issued at least five business days prior to the date production of the record is desired. The subpoena shall be returnable within 20 days of proper service, directing the hospital, nursing facility, physician, or other health care provider to produce and furnish copies of the reports and papers to the clerk who shall then make the same available to the patient, his attorney or authorized insurer. If the court finds that a hospital, nursing facility, physician, or other health care provider willfully refused to comply with a written request made in accordance with subsection B, either by willfully or arbitrarily refusing or by imposing a charge in excess of the reasonable expense of making the copies and processing the request for records, the court may award damages for all expenses incurred by the patient or authorized insurer to obtain such copies, including court costs and reasonable attorney's fees.

D. The provisions of subsections A, B, and C hereof shall apply to any health care provider whose office is located within or without the Commonwealth if the records pertain to any patient who is a party to a cause of action in any court in the Commonwealth of Virginia, and shall apply only to requests made by the patient, his attorney, his executor or administrator, or any authorized insurer, in anticipation of litigation or in the course of litigation.

E. Health care provider, as used in this section, shall have the same meaning as provided in § 32.1-127.1:03 and shall also include an independent medical copy retrieval service contracted to provide the service of retrieving, reviewing, and preparing such copies for distribution.

F. Notwithstanding the authorization to admit as evidence patient records in the form of microphotographs, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412.

G. The provisions of this section governing fees that may be charged by a health care provider whose records are subpoenaed or requested pursuant to this section shall not apply in the case of any request by a patient for his own records, which shall be governed by subsection J of § 32.1-127.1:03. This subsection shall not be construed to affect other provisions of state or federal statute, regulation or any case decision relating to charges by health care providers for copies of records requested by any person other than a patient when requesting his own records pursuant to subsection J of § 32.1-127.1:03.

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted by this section or by another provision of state or federal law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;
2. Except where specifically provided herein, the health records of minors; or
3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may disclose health records:

1. As set forth in subsection E of this section, pursuant to the written authorization of the individual or in the case of a minor, his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; also, in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H of this section, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509 and 63.2-1606;

7. Where necessary in connection with the care of the individual, including in the implementation of a health care provider's routine contact process pursuant to subdivision B 4 of § 32.1-127;

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Article 1.1 (§ 37.1-134.6 et seq.) of Chapter 4 of Title 37.1;

12. To the attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a civil commitment proceeding under § 37.1-67.3 or a judicial authorization for treatment proceeding pursuant to § 37.1-134.21;

13. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

14. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

15. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

16. To third-party payors and their agents for purposes of reimbursement;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. To the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413;

21. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

23. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote

identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

25. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Chapter 16 (§ 37.1-255 et seq.) of Title 37.1;

26. (Expires July 1, 2006) To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision D 1 of this section;

27. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

28. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title; and

29. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of this Code, federal law or state or federal regulation.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

G. A written authorization to allow release of an individual's health records shall substantially include

the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name

Health Care Entity's Name

Person, Agency, or Health Care Entity to whom disclosure is to be made

Information or Health Records to be disclosed

Purpose of Disclosure or at the Request of the Individual

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event)

Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

Relationship or Authority of Legal Representative

Date of Signature

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care

provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivisions 5 or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

§ 54.1-111. Unlawful acts; prosecution; proceedings in equity; civil penalty.

A. It shall be unlawful for any person, partnership, corporation or other entity to engage in any of the following acts:

1. Practicing a profession or occupation without holding a valid license as required by statute or regulation.
2. Making use of any designation provided by statute or regulation to denote a standard of professional or occupational competence without being duly certified or licensed.
3. Making use of any titles, words, letters or abbreviations which may reasonably be confused with a designation provided by statute or regulation to denote a standard of professional or occupational competence without being duly certified or licensed.
4. Performing any act or function which is restricted by statute or regulation to persons holding a professional or occupational license or certification, without being duly certified or licensed.
5. Failing to register as a practitioner of a profession or occupation as required by statute or regulation.
6. Materially misrepresenting facts in an application for licensure, certification or registration.
7. Willfully refusing to furnish a regulatory board information or records required or requested pursuant to statute or regulation.
8. Violating any statute or regulation governing the practice of any profession or occupation regulated pursuant to this title.
9. Refusing to process a request, tendered in accordance with the regulations of the relevant health regulatory board or applicable statutory law, for patient records or prescription dispensing records after the closing of a business or professional practice or the transfer of ownership of a business or professional practice.

Any person who willfully engages in any unlawful act enumerated in this section shall be guilty of a Class 1 misdemeanor. The third or any subsequent conviction for violating this section during a 36-month period shall constitute a Class 6 felony.

B. In addition to the criminal penalties provided for in subsection A, the Department of Professional and Occupational Regulation or the Department of Health Professions, without compliance with the Administrative Process Act (§ 2.2-4000 et seq.), shall have the authority to enforce the provisions of subsection A and may institute proceedings in equity to enjoin any person, partnership, corporation or any other entity from engaging in any unlawful act enumerated in this section and to recover a civil penalty of at least \$200 but not more than \$5,000 per violation, with each unlawful act constituting a separate violation; but in no event shall the civil penalties against any one person, partnership, corporation or other entity exceed \$25,000 per year. Such proceedings shall be brought in the name of the Commonwealth by the appropriate Department in the circuit court or general district court of the city or county in which the unlawful act occurred or in which the defendant resides.

C. This section shall not be construed to prohibit or prevent the owner of patient records from (i) retaining copies of his patient records or prescription dispensing records after the closing of a business or professional practice or the transfer of ownership of a business or professional practice or (ii) charging a reasonable fee, ~~not in excess of the amounts authorized~~ *in accordance with subsections A and B of § 8.01-413 or subsection J of § 32.1-127.1:03*, for copies of patient records, *as applicable under the circumstances.*

D. This section shall apply, mutatis mutandis, to all persons holding a multistate licensure privilege to practice nursing in the Commonwealth of Virginia.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 181

An Act to amend and reenact §§ 2.2-3705.5, 16.1-338, 20-124.6, and 54.1-2969 of the Code of Virginia, relating to health record privacy; minors' records.

[H 2516]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.5, 16.1-338, 20-124.6, and 54.1-2969 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Health records, except that such records may be personally reviewed by the individual who is the subject of such records, as provided in subsection F of § 32.1-127.1:03.

Where the person who is the subject of ~~medical~~ *health* records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the ~~medical~~ *health* records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. ~~Medical~~ *Health* records shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the ~~medical~~ *health* records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

Where the person who is the subject of ~~medical and mental~~ *health* records is under the age of 18, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated ~~or~~, a court of competent jurisdiction has restricted or denied such access, *or a parent has been denied access to the health record in accordance with § 20-124.6*. In instances where the person who is the subject thereof is an emancipated minor ~~or~~, a student in a public institution of higher education, *or is a minor who has consented to his own treatment as authorized by § 16.1-338 or 54.1-2969*, the right of access may be asserted by the subject person.

For the purposes of this chapter, statistical summaries of incidents and statistical data concerning patient abuse as may be compiled by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be open to inspection and copying as provided in § 2.2-3704. No such summaries or data shall include any patient-identifying information.

2. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

3. Reports, documentary evidence and other information as specified in §§ 2.2-706 and 63.2-104.

4. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2. However, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

5. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

6. Reports and court documents relating to involuntary admission required to be kept confidential pursuant to § 37.1-67.3.

7. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or the expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

8. Information required to be provided to the Department of Health Professions by certain licensees pursuant to § 54.1-2506.1.

9. All information and records acquired during a review of any child death by the State Child

Fatality Review team established pursuant to § 32.1-283.1, during a review of any child death by a local or regional child fatality review team established pursuant to § 32.1-283.2, and all information and records acquired during a review of any death by a family violence fatality review team established pursuant to § 32.1-283.3.

10. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

11. Records of the Intervention Program Committee within the Department of Health Professions, to the extent such records may identify any practitioner who may be, or who is actually, impaired to the extent disclosure is prohibited by § 54.1-2517.

12. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5, to the extent such records contain (i) medical or mental records, or other data identifying individual patients or (ii) proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical or scholarly issues, when such information has not been publicly released, published, copyrighted or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

13. Any record copied, recorded or received by the Commissioner of Health in the course of an examination, investigation or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

14. Records, information and statistical registries required to be kept confidential pursuant to §§ 63.2-102 and 63.2-104.

15. (For effective date - See note) All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring Program pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and any material relating to the operation or security of the Program.

16. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept confidential pursuant to § 38.2-5002.2.

17. Records of the State Health Commissioner relating to the health of any person or persons subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1; this provision shall not, however, be construed to prohibit the disclosure of statistical summaries, abstracts or other information in aggregate form.

18. Records containing the names and addresses or other contact information of persons receiving transportation services from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under § 63.2-600.

§ 16.1-338. Parental admission of minors younger than 14 and nonobjecting minors 14 years of age or older.

A. A minor younger than ~~fourteen~~ 14 years of age may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent. A minor ~~fourteen~~ 14 years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within ~~forty-eight~~ 48 hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. If the minor is ~~fourteen~~ 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by this section and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the evaluator.

C. Within ~~ten~~ 10 days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the

admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, or if a minor ~~fourteen~~ 14 or older objects at any time to further treatment, the minor shall be discharged within ~~forty-eight~~ 48 hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to §§ 16.1-339, 16.1-340, or § 16.1-345.

E. Inpatient treatment of a minor hospitalized under this section may not exceed ~~ninety~~ 90 consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than ~~fourteen~~ 14 and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within ~~ten~~ 10 days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.

G. Any minor 14 years of age or older who joins in an application and consents to admission pursuant to subsection A, shall, in addition to his parent, have the right to access his health information. The concurrent authorization of both the parent and the minor shall be required to disclose such minor's health information.

§ 20-124.6. Access to minor's records.

A. Notwithstanding any other provision of law, neither parent, regardless of whether such parent has custody, shall be denied access to the academic, ~~medical, hospital or other~~ health records of that parent's minor child unless otherwise ordered by the court for good cause shown *or pursuant to subsection B.*

B. In the case of health records, access may also be denied if the minor's treating physician or the minor's treating clinical psychologist has made a part of the minor's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the requesting parent of such health records would be reasonably likely to cause substantial harm to the minor or another person. If a health care entity denies a parental request for access to, or copies of, a minor's health record, the health care entity denying the request shall comply with the provisions of subsection F of § 32.1-127.1:03. The minor or his parent, either or both, shall have the right to have the denial reviewed as specified in subsection F of § 32.1-127.1:03 to determine whether to make the minor's health record available to the requesting parent.

C. For the purposes of this section, the meaning of the term "health record" or the plural thereof and the term "health care entity" shall be as defined in subsection B of § 32.1-127.1:03.

§ 54.1-2969. Authority to consent to surgical and medical treatment of certain minors.

A. Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, as follows:

1. Upon judges with respect to minors whose custody is within the control of their respective courts.
2. Upon local directors of social services or their designees with respect to (i) minors who are committed to the care and custody of the local board by courts of competent jurisdiction, (ii) minors who are taken into custody pursuant to § 63.2-1517, and (iii) minors who are entrusted to the local board by the parent, parents or guardian, when the consent of the parent or guardian cannot be obtained immediately and, in the absence of such consent, a court order for such treatment cannot be obtained immediately.
3. Upon the Director of the Department of Corrections or the Director of the Department of Juvenile Justice or his designees with respect to any minor who is sentenced or committed to his custody.
4. Upon the principal executive officers of state institutions with respect to the wards of such institutions.
5. Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.

6. Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

B. Whenever the consent of the parent or guardian of any minor who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of ~~this~~ the Commonwealth or his whereabouts is unknown or he cannot be consulted with promptness reasonable under the circumstances, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of juvenile and domestic relations district courts.

C. Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon qualified emergency medical services personnel as defined in § 32.1-111.1 at the scene of an accident, fire or other emergency, a licensed health professional, or a licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor ~~fourteen~~ 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

D. Whenever delay in providing transportation to a minor from the scene of an accident, fire or other emergency prior to hospital admission may adversely affect such minor's recovery and no person authorized in this section to consent to such transportation for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon emergency medical services personnel as defined in § 32.1-111.1, by reason of lack of consent to such transportation. However, in the case of a minor ~~fourteen~~ 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

E. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;

2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;

3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in § 37.1-203;

4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance; ~~or.~~

~~5. The release of medical records~~ *A minor shall also be deemed an adult for the purpose of accessing or authorizing the disclosure of medical records* related to subdivisions 1 ~~and 2~~ through 4.

F. Except for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment.

G. A pregnant minor shall be deemed an adult for the sole purpose of giving consent for herself and her child to surgical and medical treatment relating to the delivery of her child when such surgical or medical treatment is provided during the delivery of the child or the duration of the hospital admission for such delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child.

H. Any minor ~~seventeen~~ 17 years of age may, with the consent of a parent or legal guardian, consent to donate blood and may donate blood if such minor meets donor eligibility requirements. However, parental consent to donate blood by any minor ~~seventeen~~ 17 years of age shall not be required if such minor receives no consideration for his blood donation and the procurer of the blood is a nonprofit, voluntary organization.

I. Any judge, local director of social services, Director of the Department of Corrections, Director of the Department of Juvenile Justice, or principal executive officer of any state or other institution or agency who consents to surgical or medical treatment of a minor in accordance with this section shall make a reasonable effort to notify the minor's parent or guardian of such action as soon as practicable.

J. Nothing in subsection G shall be construed to permit a minor to consent to an abortion without complying with § 16.1-241.

K. Nothing in ~~subdivision 3~~ of subsection E shall prevent a parent, legal guardian or person standing in loco parentis from obtaining (i) the results of a minor's nondiagnostic drug test when the minor is not receiving care, treatment or rehabilitation for substance abuse as defined in § 37.1-203 or (ii) *a minor's other health records, except when the minor's treating physician or the minor's treating clinical psychologist has determined, in the exercise of his professional judgment, that the disclosure of health records to the parent, legal guardian, or person standing in loco parentis would be reasonably likely to cause substantial harm to the minor or another person pursuant to subsection B of § 20-124.6.*

2005 SESSION

INTRODUCED

054556136

SENATE BILL NO. 1041

Offered January 12, 2005

Prefiled January 12, 2005

A BILL to amend the Code of Virginia by adding in Article 13 of Chapter 3 of Title 58.1 a section numbered 58.1-439.12.1, relating to employer provided long-term care insurance tax credit.

Patrons—Lambert, Blevins, Bolling, Martin and Puller; Delegates: Athey, Brink, Hamilton, Landes and Morgan

Referred to Committee on Finance

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 13 of Chapter 3 of Title 58.1 a section numbered 58.1-439.12.1 as follows:

§ 58.1-439.12.1. Tax credit for employer provided long-term care insurance.

A. For taxable years beginning on and after January 1, 2006, a taxpayer who operates a business within the Commonwealth that provides benefits to its employees shall be allowed a credit against the taxes imposed pursuant to Articles 2 (§ 58.1-320 et seq.) and 10 (§ 58.1-400 et seq.) of this chapter in an amount equal to 10 percent of the premium costs incurred during the taxable year to provide long-term care insurance, as defined in § 38.2-5200, as part of an employee benefits package. The total credit allowed to any taxpayer under this section in any taxable year shall not exceed (i) \$5,000 or (ii) \$100 per employee, whichever is less.

B. The taxpayer shall submit with his income tax return such receipts, premium statements, and other documentation as required by the Department of Taxation to confirm the taxpayer's statement of the total amount paid for the employees' long-term care insurance.

C. Any tax credit under this section not usable for the taxable year in which the long-term care insurance premium was paid may be carried over for the next three taxable years. The amount of credit allowed pursuant to this section shall not exceed the tax imposed for any taxable year. No credit shall be carried back to a preceding taxable year.

D. For purposes of this section, the amount of any credit attributable to the purchase of long-term care insurance by a partnership or electing small business corporation (S corporation) shall be allocated to the individual partners or shareholders in proportion to their ownership or interest in the partnership or S corporation.

INTRODUCED

SB1041

1/18/05 0:24

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 39

An Act to amend and reenact § 32.1-127.1:03 of the Code of Virginia, relating to health records privacy.

[S 1064]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-127.1:03 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted or required by this section or by ~~another provision~~ *other provisions* of state or federal law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Pursuant to this subsection:

1. Health care entities shall disclose health records to the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413.

2. Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

3. No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health

care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

"Psychotherapy notes" means comments, recorded in any medium by a health care provider who is a mental health professional, documenting or analyzing the contents of conversation during a private counseling session with an individual or a group, joint, or family counseling session that are separated from the rest of the individual's health record. "Psychotherapy notes" shall not include annotations relating to medication and prescription monitoring, counseling session start and stop times, treatment modalities and frequencies, clinical test results, or any summary of any symptoms, diagnosis, prognosis, functional status, treatment plan, or the individual's progress to date.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;

2. Except where specifically provided herein, the health records of minors; or

3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may, *and, when required by other provisions of state law, shall*, disclose health records:

1. As set forth in subsection E of ~~this section~~, pursuant to the written authorization of (i) the individual or (ii) in the case of a minor, (a) his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; ~~also~~, or (b) the minor himself, if he has consented to his own treatment pursuant to subsection E of § 54.1-2969, or (iii) in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H of ~~this section~~, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509 and 63.2-1606;

7. Where necessary in connection with the care of the individual, ~~including in the implementation of a health care provider's routine contact process pursuant to subdivision B 4 of § 32.1-127;~~

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Article 1.1 (§ 37.1-134.6 et seq.) of Chapter 4 of Title 37.1;

12. To the attorney appointed by the court to represent an individual who is or has been a patient

who is the subject of a civil commitment proceeding under § 37.1-67.3 or a judicial authorization for treatment proceeding pursuant to § 37.1-134.21;

13. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

14. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

15. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

16. To third-party payors and their agents for purposes of reimbursement;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. ~~To the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413~~ *Where necessary in connection with the implementation of a hospital's routine contact process for organ donation pursuant to subdivision B 4 of § 32.1-127;*

21. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

23. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

25. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Chapter 16 (§ 37.1-255 et seq.) of Title 37.1;

26. (Expires July 1, 2006) To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision ~~D~~ **I** of this ~~section~~ *subsection*;

27. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

28. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title; and

29. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment.

Notwithstanding the provisions of subdivisions 1 through 29 of this subsection, a health care entity shall obtain an individual's written authorization for any disclosure of psychotherapy notes, except when disclosure by the health care entity is (i) for its own training programs in which students, trainees, or practitioners in mental health are being taught under supervision to practice or to improve their skills in group, joint, family, or individual counseling; (ii) to defend itself or its employees or staff against any accusation of wrongful conduct; (iii) in the discharge of the duty, in accordance with subsection B of

§ 54.1-2400.1, to take precautions to protect third parties from violent behavior or other serious harm; (iv) required in the course of an investigation, audit, review, or proceeding regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity; or (v) otherwise required by law.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requestor as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of this Code, federal law or state or federal regulation law.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

Further, nothing herein shall be construed as giving, or interpreted to bestow the right to receive copies of, or otherwise obtain access to, psychotherapy notes to any individual or any person authorized to act on his behalf.

G. A written authorization to allow release of an individual's health records shall substantially include the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name
Health Care Entity's Name
Person, Agency, or Health Care Entity to whom disclosure is to be made
Information or Health Records to be disclosed
Purpose of Disclosure or at the Request of the Individual

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession

of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event)
Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign

Relationship or Authority of Legal Representative

Date of Signature

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9 of this subsection, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8 of *this subsection*.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in ~~subdivisions~~ *subdivision* 5 or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative

agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 503

An Act to amend and reenact §§ 2.2-2818, 6.1-2.9:8, 38.2-5601, and 38.2-5602 of the Code of Virginia, to amend the Code of Virginia by adding a section numbered 38.2-5602.1, and to repeal §§ 38.2-5600 and 38.2-5603 of the Code of Virginia, relating to health savings accounts; the Virginia Health Savings Account Plan; high deductible health plans.

[S 1097]

Approved March 22, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 6.1-2.9:8, 38.2-5601, and 38.2-5602 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-5602.1 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. (Contingent expiration date) 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 physician, (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;

a. (Contingent effective date) 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.

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 physicians 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 subdivision 1, 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 subdivision 1, 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.

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

The reimbursement for patient costs incurred during participation in clinical trials for treatment

studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

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

"FDA" means the Federal Food and Drug Administration.

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

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

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

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

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

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

- a. The National Cancer Institute;
- b. An NCI cooperative group or an NCI center;
- c. The FDA in the form of an investigational new drug application;
- d. The federal Department of Veterans Affairs; or
- e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

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

Coverage under this section shall apply only if:

- (1) There is no clearly superior, noninvestigational treatment alternative;
- (2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the ~~noninvestigational~~ *noninvestigational* alternative; and
- (3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

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

18. Include coverage for biologically based mental illness.

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

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage 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 copayment and 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. (Contingent expiration date) 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 or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

22. (Contingent effective date) 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, 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.

"State employee" means state employee as defined in § 51.1-124.3, employee as defined in

§ 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Ombudsman shall:

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

2. Answer inquiries from covered employees by telephone and electronic mail.
3. Provide to covered employees information concerning the state health plans.
4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.
5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.
6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.
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. 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.

O. 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.

§ 6.1-2.9:8. Medical savings accounts and health savings accounts.

To the extent allowed by federal law, a bank, insured savings institution, or credit union may act as a trustee or custodian of *health savings accounts established with financial institutions under § 223 of the United States Internal Revenue Code of 1986, as amended from time to time, and medical savings accounts established with financial institutions under § 220 of the United States Internal Revenue Code of 1986, as amended from time to time.* Contributions may be accepted and interest thereon retained by such institution pursuant to forms provided by it and may be invested in accounts of the institution in accordance with the terms upon which such contributions were accepted. The financial institution shall administer such accounts in accordance with the requirements of federal law.

CHAPTER 56.

THE VIRGINIA ~~MEDICAL~~ HEALTH SAVINGS ACCOUNT ~~ACT~~ PLAN.

§ 38.2-5601. The Virginia Health Savings Account Plan.

A. The Department of Taxation and the ~~Bureau of Insurance Commission~~ shall ~~develop~~ amend the Virginia Medical Savings Account Plan *prepared pursuant to former § 38.2-5600 in order to address the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, permitting eligible individuals to establish health savings accounts pursuant to § 223 of the Internal Revenue Code of 1986, as amended, which amended Plan shall be designated as the Virginia Health Savings Account Plan. The Department of Taxation and the Commission shall present the Virginia Health Savings Account Plan to the chairs of the House Appropriations; Finance; Health, Welfare and Institutions; and Commerce and Labor Committees and the Senate Finance; Education and Health; and Commerce and Labor Committees by January 1, 2006. Thereafter the Department of Taxation and the Commission shall update the Plan annually and provide copies of such updates to the chairs of such committees.*

B. The Virginia Health Savings Account Plan shall set forth the requirements for establishing

~~medical, consistent with federal law authorizing the establishment and use of health savings accounts, identify measures by private and public entities that will increase the utilization and efficacy of health savings accounts, which shall include, but not be limited to by the Commonwealth's residents, employers, and providers of health care coverage. The Plan shall include recommendations for legislation that would increase the attractiveness of health savings accounts, or eliminate barriers to their use, by providing:~~

- ~~a. Definitions of eligible participants;~~
- ~~b. Criteria for accounts, including, but not limited to, such matters as trustees, maximum amounts, etc. and the rollover of balances in medical savings accounts to health savings accounts;~~
- ~~e. A system for providing a viable sliding scale for refundable tax credits for the working poor.~~
- ~~d. A system for allowing voluntary employer contributions to the medical savings accounts and tax deductions for such contributions.~~
- ~~e. A system for allowing tax credits for health care practitioners providing services to holders of medical savings accounts at reduced cost or without compensation.~~
- ~~f. c. Measures that would encourage public and private employers to offer, as part of a cafeteria menu of insurance plans to provide, high-deductible, indemnity health insurance policies, health plans that would qualify for a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended; and~~
- ~~g. d. Any other specific provisions necessary appropriate to the efficient implementation of the Virginia Medical Savings Account Plan maximize the use of health savings accounts within the Commonwealth.~~

~~C. The Plan shall include a report by the Commission on the availability of high deductible health plans, as defined in § 223 (c) (2) of the Internal Revenue Code of 1986, as amended, in the Commonwealth.~~

~~D. The Plan shall include recommendations by the Department of Taxation for a system of income tax deductions or refundable credits, consistent with federal law and regulation, for (i) employers who voluntarily contribute to their employees' health savings accounts, (ii) health care providers who participate in providing care to health savings account holders at a reduced cost or without compensation, and (iii) eligible individuals, as defined in § 223 (a) of the Internal Revenue Code of 1986, as amended, who qualify under applicable federal or state definitions as members of the working poor.~~

§ 38.2-5602. Operation of medical savings accounts.

Medical savings accounts may be established in the Commonwealth, and may be converted to health savings accounts, pursuant to applicable federal law and regulation.

§ 38.2-5602.1. Operation of health savings accounts; high deductible health plans.

Health savings accounts may be established in the Commonwealth pursuant to applicable federal law and regulation. Unless otherwise prohibited by any provision of this title, any health carrier, as defined in § 38.2-5800, authorized to conduct business in the Commonwealth may offer a high deductible health plan that would qualify for and may be offered in conjunction with a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

2. That §§ 38.2-5600 and 38.2-5603 of the Code of Virginia are repealed.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 227

An Act to amend and reenact §§ 2.2-3705.5, 16.1-338, 20-124.6, and 54.1-2969 of the Code of Virginia, relating to health record privacy; minors' records.

[S 1109]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-3705.5, 16.1-338, 20-124.6, and 54.1-2969 of the Code of Virginia are amended and reenacted as follows:

§ 2.2-3705.5. Exclusions to application of chapter; health and social services records.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. Health records, except that such records may be personally reviewed by the individual who is the subject of such records, as provided in subsection F of § 32.1-127.1:03.

Where the person who is the subject of ~~medical~~ *health* records is confined in a state or local correctional facility, the administrator or chief medical officer of such facility may assert such confined person's right of access to the ~~medical~~ *health* records if the administrator or chief medical officer has reasonable cause to believe that such confined person has an infectious disease or other medical condition from which other persons so confined need to be protected. ~~Medical~~ *Health* records shall only be reviewed and shall not be copied by such administrator or chief medical officer. The information in the ~~medical~~ *health* records of a person so confined shall continue to be confidential and shall not be disclosed by the administrator or chief medical officer of the facility to any person except the subject or except as provided by law.

Where the person who is the subject of ~~medical and mental~~ *health* records is under the age of 18, his right of access may be asserted only by his guardian or his parent, including a noncustodial parent, unless such parent's parental rights have been terminated or, a court of competent jurisdiction has restricted or denied such access, *or a parent has been denied access to the health record in accordance with § 20-124.6*. In instances where the person who is the subject thereof is an emancipated minor or, a student in a public institution of higher education, *or is a minor who has consented to his own treatment as authorized by § 16.1-338 or 54.1-2969*, the right of access may be asserted by the subject person.

For the purposes of this chapter, statistical summaries of incidents and statistical data concerning patient abuse as may be compiled by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services shall be open to inspection and copying as provided in § 2.2-3704. No such summaries or data shall include any patient-identifying information.

2. Applications for admission to examinations or for licensure and scoring records maintained by the Department of Health Professions or any board in that department on individual licensees or applicants. However, such material may be made available during normal working hours for copying, at the requester's expense, by the individual who is the subject thereof, in the offices of the Department of Health Professions or in the offices of any health regulatory board, whichever may possess the material.

3. Reports, documentary evidence and other information as specified in §§ 2.2-706 and 63.2-104.

4. Investigative notes; proprietary information not published, copyrighted or patented; information obtained from employee personnel records; personally identifiable information regarding residents, clients or other recipients of services; and other correspondence and information furnished in confidence to the Department of Social Services in connection with an active investigation of an applicant or licensee pursuant to Chapters 17 (§ 63.2-1700 et seq.) and 18 (§ 63.2-1800 et seq.) of Title 63.2. However, nothing in this section shall prohibit disclosure of information from the records of completed investigations in a form that does not reveal the identity of complainants, persons supplying information, or other individuals involved in the investigation.

5. Information and records collected for the designation and verification of trauma centers and other specialty care centers within the Statewide Emergency Medical Services System and Services pursuant to Article 2.1 (§ 32.1-111.1 et seq.) of Chapter 4 of Title 32.1.

6. Reports and court documents relating to involuntary admission required to be kept confidential pursuant to § 37.1-67.3.

7. Data formerly required to be submitted to the Commissioner of Health relating to the establishment of new or the expansion of existing clinical health services, acquisition of major medical equipment, or certain projects requiring capital expenditures pursuant to former § 32.1-102.3:4.

8. Information required to be provided to the Department of Health Professions by certain licensees pursuant to § 54.1-2506.1.

9. All information and records acquired during a review of any child death by the State Child

Fatality Review team established pursuant to § 32.1-283.1, during a review of any child death by a local or regional child fatality review team established pursuant to § 32.1-283.2, and all information and records acquired during a review of any death by a family violence fatality review team established pursuant to § 32.1-283.3.

10. Patient level data collected by the Board of Health and not yet processed, verified, and released, pursuant to § 32.1-276.9, to the Board by the nonprofit organization with which the Commissioner of Health has contracted pursuant to § 32.1-276.4.

11. Records of the Intervention Program Committee within the Department of Health Professions, to the extent such records may identify any practitioner who may be, or who is actually, impaired to the extent disclosure is prohibited by § 54.1-2517.

12. Records submitted as a grant application, or accompanying a grant application, to the Commonwealth Neurotrauma Initiative Advisory Board pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5, to the extent such records contain (i) medical or mental records, or other data identifying individual patients or (ii) proprietary business or research-related information produced or collected by the applicant in the conduct of or as a result of study or research on medical, rehabilitative, scientific, technical or scholarly issues, when such information has not been publicly released, published, copyrighted or patented, if the disclosure of such information would be harmful to the competitive position of the applicant.

13. Any record copied, recorded or received by the Commissioner of Health in the course of an examination, investigation or review of a managed care health insurance plan licensee pursuant to §§ 32.1-137.4 and 32.1-137.5, including books, records, files, accounts, papers, documents, and any or all computer or other recordings.

14. Records, information and statistical registries required to be kept confidential pursuant to §§ 63.2-102 and 63.2-104.

15. (For effective date - See note) All data, records, and reports relating to the prescribing and dispensing of covered substances to recipients and any abstracts from such data, records, and reports that are in the possession of the Prescription Monitoring Program pursuant to Chapter 25.2 (§ 54.1-2519 et seq.) of Title 54.1 and any material relating to the operation or security of the Program.

16. Records of the Virginia Birth-Related Neurological Injury Compensation Program required to be kept confidential pursuant to § 38.2-5002.2.

17. Records of the State Health Commissioner relating to the health of any person or persons subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of Title 32.1; this provision shall not, however, be construed to prohibit the disclosure of statistical summaries, abstracts or other information in aggregate form.

18. Records containing the names and addresses or other contact information of persons receiving transportation services from a state or local public body or its designee under Title II of the Americans with Disabilities Act, (42 U.S.C. § 12131 et seq.) or funded by Temporary Assistance for Needy Families (TANF) created under § 63.2-600.

§ 16.1-338. Parental admission of minors younger than 14 and nonobjecting minors 14 years of age or older.

A. A minor younger than ~~fourteen~~ 14 years of age may be admitted to a willing mental health facility for inpatient treatment upon application and with the consent of a parent. A minor ~~fourteen~~ 14 years of age or older may be admitted to a willing mental health facility for inpatient treatment upon the joint application and consent of the minor and the minor's parent.

B. Admission of a minor under this section shall be approved by a qualified evaluator who has conducted a personal examination of the minor within ~~forty-eight~~ 48 hours after admission and has made the following written findings:

1. The minor appears to have a mental illness serious enough to warrant inpatient treatment and is reasonably likely to benefit from the treatment; and

2. The minor has been provided with a clinically appropriate explanation of the nature and purpose of the treatment; and

3. If the minor is ~~fourteen~~ 14 years of age or older, that he has been provided with an explanation of his rights under this Act as they would apply if he were to object to admission, and that he has consented to admission; and

4. All available modalities of treatment less restrictive than inpatient treatment have been considered and no less restrictive alternative is available that would offer comparable benefits to the minor.

If admission is sought to a state hospital, the community services board serving the area in which the minor resides shall provide the examination required by this section and shall ensure that the necessary written findings have been made before approving the admission. A copy of the written findings of the evaluation required by this section shall be provided to the consenting parent and the parent shall have the opportunity to discuss the findings with the evaluator.

C. Within ~~ten~~ 10 days after the admission of a minor under this section, the director of the facility or the director's designee shall ensure that an individualized plan of treatment has been prepared by the provider responsible for the minor's treatment and has been explained to the parent consenting to the

admission and to the minor. The minor shall be involved in the preparation of the plan to the maximum feasible extent consistent with his ability to understand and participate, and the minor's family shall be involved to the maximum extent consistent with the minor's treatment needs. The plan shall include a preliminary plan for placement and aftercare upon completion of inpatient treatment and shall include specific behavioral and emotional goals against which the success of treatment may be measured. A copy of the plan shall be provided to the minor and to his parents.

D. If the parent who consented to a minor's admission under this section revokes his consent at any time, or if a minor ~~fourteen~~ 14 or older objects at any time to further treatment, the minor shall be discharged within ~~forty-eight~~ 48 hours to the custody of such consenting parent unless the minor's continued hospitalization is authorized pursuant to §§ 16.1-339, 16.1-340, or §-16.1-345.

E. Inpatient treatment of a minor hospitalized under this section may not exceed ~~ninety~~ 90 consecutive days unless it has been authorized by appropriate hospital medical personnel, based upon their written findings that the criteria set forth in subsection B of this section continue to be met, after such persons have examined the minor and interviewed the consenting parent and reviewed reports submitted by members of the facility staff familiar with the minor's condition.

F. Any minor admitted under this section while younger than ~~fourteen~~ 14 and his consenting parent shall be informed orally and in writing by the director of the facility for inpatient treatment within ~~ten~~ 10 days of his fourteenth birthday that continued voluntary treatment under the authority of this section requires his consent.

G. Any minor 14 years of age or older who joins in an application and consents to admission pursuant to subsection A, shall, in addition to his parent, have the right to access his health information. The concurrent authorization of both the parent and the minor shall be required to disclose such minor's health information.

§ 20-124.6. Access to minor's records.

A. Notwithstanding any other provision of law, neither parent, regardless of whether such parent has custody, shall be denied access to the academic, ~~medical, hospital or other~~ health records of that parent's minor child unless otherwise ordered by the court for good cause shown or pursuant to subsection B.

B. In the case of health records, access may also be denied if the minor's treating physician or the minor's treating clinical psychologist has made a part of the minor's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the requesting parent of such health records would be reasonably likely to cause substantial harm to the minor or another person. If a health care entity denies a parental request for access to, or copies of, a minor's health record, the health care entity denying the request shall comply with the provisions of subsection F of § 32.1-127.1:03. The minor or his parent, either or both, shall have the right to have the denial reviewed as specified in subsection F of § 32.1-127.1:03 to determine whether to make the minor's health record available to the requesting parent.

C. For the purposes of this section, the meaning of the term "health record" or the plural thereof and the term "health care entity" shall be as defined in subsection B of § 32.1-127.1:03.

§ 54.1-2969. Authority to consent to surgical and medical treatment of certain minors.

A. Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, as follows:

1. Upon judges with respect to minors whose custody is within the control of their respective courts.
2. Upon local directors of social services or their designees with respect to (i) minors who are committed to the care and custody of the local board by courts of competent jurisdiction, (ii) minors who are taken into custody pursuant to § 63.2-1517, and (iii) minors who are entrusted to the local board by the parent, parents or guardian, when the consent of the parent or guardian cannot be obtained immediately and, in the absence of such consent, a court order for such treatment cannot be obtained immediately.

3. Upon the Director of the Department of Corrections or the Director of the Department of Juvenile Justice or his designees with respect to any minor who is sentenced or committed to his custody.

4. Upon the principal executive officers of state institutions with respect to the wards of such institutions.

5. Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.

6. Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

B. Whenever the consent of the parent or guardian of any minor who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of ~~this~~ the Commonwealth or his whereabouts is unknown or he cannot be consulted with promptness reasonable under the circumstances, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of juvenile and domestic relations district courts.

C. Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon qualified emergency medical services personnel as defined in § 32.1-111.1 at the scene of an accident, fire or other emergency, a licensed health professional, or a licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor ~~fourteen~~ 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

D. Whenever delay in providing transportation to a minor from the scene of an accident, fire or other emergency prior to hospital admission may adversely affect such minor's recovery and no person authorized in this section to consent to such transportation for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon emergency medical services personnel as defined in § 32.1-111.1, by reason of lack of consent to such transportation. However, in the case of a minor ~~fourteen~~ 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

E. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;

2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;

3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in § 37.1-203; *or*

4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance; ~~or~~

~~5. The release of medical records.~~ *A minor shall also be deemed an adult for the purpose of accessing or authorizing the disclosure of medical records related to subdivisions 1 and 2 through 4.*

F. Except for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment.

G. A pregnant minor shall be deemed an adult for the sole purpose of giving consent for herself and her child to surgical and medical treatment relating to the delivery of her child when such surgical or medical treatment is provided during the delivery of the child or the duration of the hospital admission for such delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child.

H. Any minor ~~seventeen~~ 17 years of age may, with the consent of a parent or legal guardian, consent to donate blood and may donate blood if such minor meets donor eligibility requirements. However, parental consent to donate blood by any minor ~~seventeen~~ 17 years of age shall not be required if such minor receives no consideration for his blood donation and the procurer of the blood is a nonprofit, voluntary organization.

I. Any judge, local director of social services, Director of the Department of Corrections, Director of the Department of Juvenile Justice, or principal executive officer of any state or other institution or agency who consents to surgical or medical treatment of a minor in accordance with this section shall make a reasonable effort to notify the minor's parent or guardian of such action as soon as practicable.

J. Nothing in subsection G shall be construed to permit a minor to consent to an abortion without complying with § 16.1-241.

K. Nothing in ~~subdivision 3 of~~ subsection E shall prevent a parent, legal guardian or person standing in loco parentis from obtaining *(i)* the results of a minor's nondiagnostic drug test when the minor is not receiving care, treatment or rehabilitation for substance abuse as defined in § 37.1-203 *or (ii) a minor's other health records, except when the minor's treating physician or the minor's treating clinical psychologist has determined, in the exercise of his professional judgment, that the disclosure of health records to the parent, legal guardian, or person standing in loco parentis would be reasonably likely to cause substantial harm to the minor or another person pursuant to subsection B of § 20-124.6.*

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 43

An Act to repeal Chapter 12 (§§ 37.1-225 through 37.1-233) of Title 37.1 of the Code of Virginia, relating to disclosure of patient information by certain health care providers.

[S 1110]

Approved March 20, 2005

Be it enacted by the General Assembly of Virginia:

- 1. That Chapter 12 (§§ 37.1-225 through 37.1-233) of Title 37.1 of the Code of Virginia is repealed.**

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 717

An Act to amend and reenact §§ 32.1-65 through 32.1-67.1 of the Code of Virginia and to repeal the second enactment of Chapter 440 of the Acts of Assembly of 2002, relating to newborn screening services.

[S 1184]

Approved March 25, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-65 through 32.1-67.1 of the Code of Virginia are amended and reenacted as follows:

Article 7.

Detection and Control of Phenylketonuria and Other Inborn Errors of Metabolism Newborn Screening.

§ 32.1-65. Certain newborn screening required.

In order to prevent mental retardation, and permanent disability or death, every infant who is born in this the Commonwealth shall be subjected to a screening test for biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, congenital adrenal hyperplasia, medium chain acyl-CoA dehydrogenase (MCAD or MCADH) deficiency, and Maple Syrup Urine Disease, and each infant determined at risk shall be subject to a screening test for sickle cell diseases tests for various disorders consistent with, but not necessarily identical to, the uniform condition panel recommended by the American College of Medical Genetics in its report, *Newborn Screening: Toward a Uniform Screening Panel and System*, that was produced for the U.S. Department of Health and Human Services. Further, upon the issuance of guidance for states' newborn screening programs by the federal Department of Health and Human Services, every infant who is born in the Commonwealth shall be screened for a panel of disorders consistent with, but not necessarily identical to, the federal guidance document.

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

The physician or certified nurse midwife in charge of the infant's care after delivery shall cause such test tests to be performed. The screening tests shall be performed by the Division of Consolidated Laboratory Services or any other laboratory the Department of Health has contracted with to provide this service.

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

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

Whenever a newborn screening test result indicates suspicion of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease or any sickle cell disease any condition pursuant to § 32.1-65, the Commissioner shall notify forthwith the attending physician and shall perform or provide for any additional testing required to confirm or disprove the diagnosis of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease or the sickle cell disease. All physicians, certified nurse midwives, public health nurses, or any nurse receiving such test result, and administrators of hospitals in this the Commonwealth, shall report the discovery of all cases of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease any condition for which newborn screening is conducted pursuant to § 32.1-65 to the Commissioner; as well as sickle cell diseases in infants less than one year of age for infants and children up to two years of age.

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

Infants identified with any condition for which newborn screening is conducted pursuant to § 32.1-65 shall be eligible for the services of the Children with Special Health Care Needs Program administered by the Department of Health. The Board of Health shall promulgate such regulations as may be necessary to implement Newborn Screening Services and the Children with Special Health Care Needs Program. The Board's regulations shall include, but not be limited to, a list of newborn screening tests conducted pursuant to § 32.1-65, follow-up procedures, appropriate referral processes, and services available for infants and children who have a heritable disorder or genetic disease identified through Newborn Screening Services. The Board shall recommend procedures for the treatment of biotinidase deficiency, phenylketonuria, hypothyroidism, homocystinuria, galactosemia, Maple Syrup Urine Disease and sickle cell diseases, and shall provide such treatment for infants in medically indigent families. The Board shall create procedures to provide to (i) the parents or guardian of any child or (ii) any pregnant woman, who is a legal resident of the Commonwealth and who is diagnosed as requiring treatment for phenylketonuria, the special food products required in the management of phenylketonuria out of such

funds as may be appropriated for this purpose. The special food products shall include medical formulas which are designed specifically for the treatment of phenylketonuria and low protein modified foods (not foods naturally low in protein) which are designed specifically for use in the treatment for inborn errors of metabolism. The parents or guardian of any such child, or the pregnant woman, shall, in the discretion of the Department, reimburse to the local health department the cost of such special medical formulas in an amount not to exceed two percent of their gross income. The parents or guardian of any such child, or the pregnant woman, shall, with such funds as are appropriated, receive reimbursement from the Department for the cost of such special low protein modified foods in an amount not to exceed \$2,000 per diagnosed person per year. The reimbursement required by this section shall be payable quarterly by the first day of January, April, July, and October.

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

The results of the *newborn screening programs services* conducted pursuant to this article may be used for research and collective statistical purposes. No publication of information, biomedical research, or medical data shall be made which ~~that~~ identifies any infant having a ~~genetic disease heritable or genetic disorder~~. All medical records maintained as part of *newborn screening services* ~~the screening programs~~ shall be confidential and shall be accessible only to the Board, the Commissioner, or his agents.

2. That the second enactment of Chapter 440 of the 2002 Acts of Assembly is repealed.

3. That the provisions of this act shall become effective on March 1, 2006.

4. That, notwithstanding the provisions of the third enactment clause, the Board of Health shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

051961136

SENATE BILL NO. 1187

Offered January 12, 2005

Prefiled January 12, 2005

A BILL to amend and reenact §§ 54.1-2503, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103, 63.2-1709, and 63.2-1803 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 31 of Title 54.1 a section numbered 54.1-3103.1 and by adding in Title 63.2 sections numbered 63.2-1709.1, 63.2-1709.2, and 63.2-1803.1, relating to assisted living facilities; civil penalties.

Patrons—Puller, Blevins and Lambert; Delegates: Athey, Brink, Hamilton, Landes, Morgan and O'Bannon

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That §§ 54.1-2503, 54.1-3100, 54.1-3101, 54.1-3102, 54.1-3103, 63.2-1709, and 63.2-1803 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Chapter 31 of Title 54.1 a section numbered 54.1-3103.1 and by adding in Title 63.2 sections numbered 63.2-1709.1, 63.2-1709.2, and 63.2-1803.1 as follows:

§ 54.1-2503. Boards within Department.

In addition to the Board of Health Professions, the following boards are included within the Department: Board of Audiology and Speech-Language Pathology, Board of Counseling, Board of Dentistry, Board of Funeral Directors and Embalmers, Board of Long-Term Care Administrators, Board of Medicine, Board of Nursing, Board of Nursing Home Administrators, Board of Optometry, Board of Pharmacy, Board of Physical Therapy, Board of Psychology, Board of Social Work and Board of Veterinary Medicine.

CHAPTER 31.

NURSING HOME AND ASSISTED LIVING FACILITY ADMINISTRATORS.

§ 54.1-3100. Definitions.

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

"Assisted living facility" means any public or private assisted living facility, as defined in § 63.2-100, that is required to be licensed as an assisted living facility by the Department of Social Services under the provisions of Subtitle IV (§ 63.2-1700 et seq.) of Title 63.2.

"Assisted living facility administrator" means any individual charged with the general administration of an assisted living facility, regardless of whether he has an ownership interest in the facility.

"Board" means the Board of Nursing Home Long-Term Care Administrators.

"Nursing home" means any public or private facility required to be licensed as a nursing home under the provisions of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1 and the regulations of the Board of Health.

"Nursing home administrator" means any individual charged with the general administration of a nursing home regardless of whether he has an ownership interest in the facility.

§ 54.1-3101. Board of Long-Term Care Administrators; terms; officers; quorum; special meetings.

The Board of Long-Term Care Administrators is established as a policy board, within the meaning of § 2.2-2100, in the executive branch of state government. The Board of Nursing Home Long-Term Care Administrators shall consist of seven members, four nine nonlegislative citizen members to be appointed by the Governor. Nonlegislative citizen members shall be appointed as follows: three who are licensed nursing home administrators; three who are assisted living facility administrators; two who are from professions and institutions concerned with the care and treatment of chronically ill and elderly or mentally impaired patients or residents; and one who is a resident of a nursing home or assisted living facility or a family member or guardian of a resident of a nursing home or assisted living facility. TwoOne of the licensed nursing home administrators shall be administrators an administrator of a proprietary nursing homes home. Nonlegislative citizen members of the Board shall be citizens of the Commonwealth.

TheAfter the initial staggering of terms, the terms of Board members shall be four years. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. Vacancies shall be filled in the same manner as the original appointments. All members may be reappointed.

The Board shall annually elect a chairman and vice-chairman from among its membership. FourFive members of the Board, including one who is not a licensed nursing home administrator or assisted living facility administrator, shall constitute a quorum. Special meetings of the Board shall be called by the chairman upon the written request of any three members.

INTRODUCED

SB1187

1/25/05 16:58

58 All members shall be reimbursed for all reasonable and necessary expenses incurred in the
59 performance of their duties as provided in § 2.2-2813 and 2.2-2825. Funding for the costs of expenses
60 shall be provided by the Department of Health Professions.

61 The Department of Health Professions shall provide staff support to the Board. All agencies of the
62 Commonwealth shall provide assistance to the Board, upon request.

63 The Board shall be authorized to promulgate canons of ethics under which the professional activities
64 of persons regulated shall be conducted.

65 § 54.1-3102. License required.

66 A. In order to engage in the general administration of a nursing home, it shall be necessary to hold a
67 nursing home administrator's license issued by the Board.

68 B. In order to engage in the general administration of an assisted living facility, it shall be necessary
69 to hold an assisted living facility administrator's license or a nursing home administrator's license
70 issued by the Board.

71 § 54.1-3103. Administrator required for operation of nursing home; operation after death, illness, etc.,
72 of administrator; notification of Board.

73 All licensed nursing homes within the Commonwealth shall be under the supervision of an
74 administrator licensed by the Board. If a licensed nursing home administrator dies, becomes ill, resigns
75 or is discharged, the nursing home ~~which~~ that was administered by him at the time of his death, illness,
76 resignation or discharge may continue to operate until his successor qualifies, but in no case for longer
77 than six months is permitted by the licensing authority for the nursing home. The temporary supervisor
78 or administrator shall immediately notify the Board of Nursing Home Long-Term Care Administrators
79 and the Commissioner of Health that the nursing home is operating without the supervision of a licensed
80 nursing home administrator.

81 § 54.1-3103.1. Administrator required for operation of assisted living facility; operation after death,
82 illness, etc., of administrator; notification of Board; administrators operating more than one facility.

83 A. All licensed assisted living facilities within the Commonwealth shall be under the supervision of
84 an administrator licensed by the Board. If a licensed assisted living facility administrator dies, becomes
85 ill, resigns, or is discharged, the assisted living facility that was administered by him at the time of his
86 death, illness, resignation, or discharge may continue to operate until his successor qualifies, but in no
87 case for longer than is permitted by the licensing authority for the facility. The temporary supervisor or
88 administrator shall immediately notify the Board of Long-Term Care Administrators and the
89 Commissioner of the Department of Social Services that the assisted living facility is operating without
90 the supervision of a licensed assisted living facility administrator.

91 B. Nothing in this chapter shall prohibit an assisted living administrator from serving as the
92 administrator of record for more than one assisted living facility as permitted by regulations of the
93 licensing authority for the facility.

94 § 63.2-1709. Enforcement and sanctions; assisted living facilities and adult day care centers;
95 receivership, revocation, denial, summary suspension.

96 A. The Board shall adopt regulations for the Commissioner to use in determining when the
97 imposition of administrative sanctions or initiation of court proceedings, severally or jointly, is
98 appropriate in order to ensure prompt correction of violations in assisted living facilities and adult day
99 care centers involving noncompliance with state law or regulation as discovered through any inspection
100 or investigation conducted by the Departments of Social Services, Health, or Mental Health, Mental
101 Retardation and Substance Abuse Services. The Commissioner may impose such sanctions or take such
102 actions as are appropriate for violation of any of the provisions of this subtitle or any regulation adopted
103 under any provision of this subtitle that adversely affects the health, safety or welfare of an assisted
104 living facility resident or an adult day care participant. Such sanctions or actions may include (i)
105 petitioning the court to appoint a receiver for any assisted living facility or adult day care center and (ii)
106 revoking or denying renewal of the license for the assisted living facility or adult day care center for
107 violation of any of the provisions of this subtitle, § 54.1-3408 or any regulation adopted under this
108 subtitle that violation adversely affects, or is an imminent and substantial threat to, the health, safety or
109 welfare of the person cared for therein, or for permitting, aiding or abetting the commission of any
110 illegal act in an assisted living facility or adult day care center. Further, the Commissioner may issue a
111 summary order of suspension of the license of the assisted living facility or adult day care center
112 pursuant to the procedures set forth in subsection B in conjunction with any proceeding for revocation,
113 denial, or other action when conditions or practices exist that pose an immediate and substantial threat
114 to the health, safety, and welfare of the residents or participants and the Commissioner believes the
115 operation should be suspended during the pendency of such proceeding.

116 B. The summary order of suspension shall take effect upon its issuance and shall be served on the
117 licensee or its designee as soon as practicable thereafter by personal service and certified mail, return
118 receipt requested, to the address of record of the licensee. The order shall state the time, date, and
119 location of a hearing to determine whether the suspension is appropriate. Such hearing shall be held no

120 later than three business days after the issuance of the summary order of suspension and shall be
 121 convened by the Commissioner or his designee. After such hearing, the Commissioner may issue a final
 122 order of summary suspension or may find that such summary suspension is not warranted by the facts
 123 and circumstances presented. A final order of summary suspension shall include notice that the licensee
 124 may appeal the Commissioner's decision to the appropriate circuit court no later than 10 days following
 125 issuance of the order. The sole issue before the court shall be whether the Department had reasonable
 126 grounds to require the licensee to cease operations during the pendency of the concurrent revocation,
 127 denial, or other proceeding. The concurrent revocation, denial, or other proceeding shall not be affected
 128 by the outcome of any hearing on the appropriateness of the summary suspension. Failure to comply
 129 with the summary order of suspension shall constitute an offense under subdivision 1 of § 63.2-1712.
 130 The Commissioner may require the cooperation of any other agency or subdivision of the
 131 Commonwealth in the relocation of residents of an assisted living facility whose license has been
 132 summarily suspended pursuant to this section and in any other actions necessary to reduce the risk of
 133 further harm to residents.

134 The Commissioner may revoke or deny the renewal of the license of any child welfare agency which
 135 violates any provision of this subtitle or fails to comply with the limitations and standards set forth in its
 136 license.

137 C. Notwithstanding any other provision of law, following a proceeding as provided in § 2.2-4019, the
 138 Commissioner may issue a special order for violation of any of the provisions of this subtitle,
 139 § 54.1-3408 or any regulation adopted under any provision of this subtitle that violation adversely
 140 affects, or is an imminent and substantial threat to, the health, safety or welfare of the person cared for
 141 therein, or for permitting, aiding or abetting the commission of any illegal act in an assisted living
 142 facility, adult day care center or child welfare agency. The issuance of a special order shall be
 143 considered a case decision as defined in § 2.2-4001. The Commissioner shall not delegate his authority
 144 to impose civil penalties in conjunction with the issuance of special orders.

145 D. The Commissioner may take the following actions regarding licensed assisted living facilities,
 146 adult day care centers and child welfare agencies through the issuance of a special order:

147 1. Place a licensee on probation upon finding that the licensee is substantially out of compliance with
 148 the terms of its license and that the health and safety of residents, participants or children are at risk;

149 2. Reduce licensed capacity or prohibit new admissions when the Commissioner concludes that the
 150 licensee cannot make necessary corrections to achieve compliance with regulations except by a
 151 temporary restriction of its scope of service;

152 3. Require that probationary status announcements, provisional licenses, and denial or revocation
 153 notices be posted in a prominent place at each public entrance of the licensed premises and be of
 154 sufficient size and distinction to advise consumers of serious or persistent violations;

155 4. Mandate training for the licensee or licensee's employees, with any costs to be borne by the
 156 licensee, when the Commissioner concludes that the lack of such training has led directly to violations
 157 of regulations;

158 5. Assess civil penalties of not more than \$500 per inspection upon finding that the licensee is
 159 substantially out of compliance with the terms of its license and the health and safety of residents,
 160 participants or children are at risk;

161 6. Require licensees to contact parents, guardians or other responsible persons in writing regarding
 162 health and safety violations; and

163 7. Prevent licensees who are substantially out of compliance with the licensure terms or in violation
 164 of the regulations from receiving public funds.

165 E. The Board shall adopt regulations to implement the provisions of this section.

166 § 63.2-1709.1. Enforcement and sanctions; child welfare agencies; revocation and denial.

167 The Commissioner may revoke or deny the renewal of the license of any child welfare agency that
 168 violates any provision of this subtitle or fails to comply with the limitations and standards set forth in
 169 its license.

170 § 63.2-1709.2. Enforcement and sanctions; special orders; civil penalties.

171 A. Notwithstanding any other provision of law, following a proceeding as provided in § 2.2-4019, the
 172 Commissioner may issue a special order for violation of any of the provisions of this subtitle,
 173 § 54.1-3408, or any regulation adopted under any provision of this subtitle that adversely affects, or is
 174 an imminent and substantial threat to, the health, safety, or welfare of the person cared for therein, or
 175 for permitting, aiding, or abetting the commission of any illegal act in an assisted living facility, adult
 176 day care center, or child welfare agency. The issuance of a special order shall be considered a case
 177 decision as defined in § 2.2-4001. The Commissioner shall not delegate his authority to impose civil
 178 penalties in conjunction with the issuance of special orders.

179 B. The Commissioner may take the following actions regarding assisted living facilities, adult day
 180 care centers, and child welfare agencies through the issuance of a special order:

181 1. Place a licensee on probation upon finding that the licensee is substantially out of compliance
 182 with the terms of its license and that the health and safety of residents, participants, or children are at
 183 risk;

184 2. Reduce licensed capacity or prohibit new admissions when the Commissioner concludes that the
 185 licensee cannot make necessary corrections to achieve compliance with regulations except by a
 186 temporary restriction of its scope of service;

187 3. Require that probationary status announcements, provisional licenses, and denial or revocation
 188 notices be posted in a prominent place at each public entrance of the licensed premises and be of
 189 sufficient size and distinction to advise consumers of serious or persistent violations;

190 4. Mandate training for the licensee or licensee's employees, with any costs to be borne by the
 191 licensee, when the Commissioner concludes that the lack of such training has led directly to violations
 192 of regulations;

193 5. In the case of assisted living facilities, assess civil penalties of not more than \$10,000 per
 194 inspection upon finding that the licensee is substantially out of compliance with the terms of its license
 195 and the health and safety of residents are at risk, which shall be paid into the state treasury and
 196 credited to the Assisted Living Facility Education and Technical Assistance Fund created pursuant to
 197 § 63.2-1803.1;

198 6. In the case of adult day care centers and child welfare agencies, assess civil penalties of not more
 199 than \$500 per inspection upon finding that the licensee is substantially out of compliance with the terms
 200 of its license and the health and safety of participants or children are at risk;

201 7. Require licensees to contact parents, guardians, or other responsible persons in writing regarding
 202 health and safety violations; and

203 8. Prevent licensees who are substantially out of compliance with the licensure terms or in violation
 204 of the regulations from receiving public funds.

205 C. The Board shall adopt regulations to implement the provisions of this section.

206 § 63.2-1803. Staffing of assisted living facilities.

207 A. An administrator is ~~any person meeting the qualifications for administrator of an assisted living~~
 208 ~~facility, pursuant to regulations adopted by the Board.~~ of an assisted living facility shall be licensed as
 209 an assisted living facility administrator by the Virginia Board of Long-Term Care Administrators
 210 pursuant to Chapter 31 (§ 54.1-3100 et seq.) of Title 54.1. Any person meeting the qualifications for a
 211 licensed nursing home administrator under § 54.1-3103 shall be deemed qualified to (i) serve as an
 212 administrator of an assisted living facility or (ii) serve as the administrator of both an assisted living
 213 facility and a licensed nursing home, provided the assisted living facility and licensed nursing home are
 214 part of the same building.

215 B. The assisted living facility shall have adequate and sufficient staff to provide services to attain
 216 and maintain (i) the physical, mental and psychosocial well-being of each resident as determined by
 217 resident assessments and individual plans of care and (ii) the physical safety of the residents on the
 218 premises. Upon admission and upon request, the assisted living facility shall provide in writing a
 219 description of the types of staff working in the facility and the services provided, including the hours
 220 such services are available.

221 § 63.2-1803.1. Assisted Living Facility Education and Technical Assistance Fund established.

222 There is hereby created in the state treasury a special nonreverting fund to be known as the Assisted
 223 Living Facility Education and Technical Assistance Fund, hereafter referred to as "the Fund." The Fund
 224 shall be established on the books of the Comptroller. All penalties directed to this fund by subdivision B
 225 4 of § 63.2-1709.2 and all other funds from any public or private source directed to the Fund shall be
 226 paid into the state treasury and credited to the Fund. Interest earned on moneys in the Fund shall
 227 remain in the Fund and be credited to it. Any moneys remaining the Fund, including interest thereon, at
 228 the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in
 229 the Fund shall be used solely for the purpose of providing education for staff of and technical
 230 assistance to assisted living facilities to improve the standard of care in such facilities. Expenditures and
 231 disbursements from the Fund shall be made by the State Treasurer on warrants issued by the
 232 Comptroller upon written request signed by the Commissioner.

233 2. That this act shall take effect on July 1, 2005; however, the provisions of this act in
 234 §§ 54.1-3102, 54.1-3103.1, and 63.2-1803 shall become effective July 1, 2007.

235 3. That the Board of Long-Term Care Administrators shall submit the proposed criteria for
 236 licensing assisted living facility administrators to the chairmen of the House Committee on Health,
 237 Welfare and Institutions, Senate Committee on Education and Health, and Joint Commission on
 238 Health Care on or before January 1, 2006.

VIRGINIA ACTS OF ASSEMBLY -- 2005 SESSION

CHAPTER 697

An Act to amend and reenact §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the Code of Virginia, relating to charges for copying health records.

[S 1203]

Approved March 23, 2005

Be it enacted by the General Assembly of Virginia:

1. That §§ 8.01-413, 32.1-127.1:03, and 54.1-111 of the Code of Virginia are amended and reenacted as follows:

§ 8.01-413. Certain copies of health care provider's records or papers of patient admissible; right of patient, his attorney and authorized insurer to copies of such records or papers; subpoena; damages, costs and attorneys' fees.

A. In any case where the hospital, nursing facility, physician's, or other health care provider's original records or papers of any patient in a hospital or institution for the treatment of physical or mental illness are admissible or would be admissible as evidence, any typewritten copy, photograph, photostatted copy, or microphotograph or printout or other hard copy generated from computerized or other electronic storage, microfilm, or other photographic, mechanical, electronic or chemical storage process thereof shall be admissible as evidence in any court of this Commonwealth in like manner as the original, if the printout or hard copy or microphotograph or photograph is properly authenticated by the employees having authority to release or produce the original records.

Any hospital, nursing facility, physician, or other health care provider whose records or papers relating to any such patient are subpoenaed for production as provided by law may comply with the subpoena by a timely mailing to the clerk issuing the subpoena or in whose court the action is pending properly authenticated copies, photographs or microphotographs in lieu of the originals. The court whose clerk issued the subpoena or, in the case of an attorney-issued subpoena, in which the action is pending, may, after notice to such hospital, nursing facility, physician, or other health care provider, enter an order requiring production of the originals, if available, of any stored records or papers whose copies, photographs or microphotographs are not sufficiently legible.

Except as provided in subsection G, the party requesting the subpoena duces tecum or on whose behalf an attorney-issued subpoena duces tecum was issued shall be liable for the reasonable charges of the hospital, nursing facility, physician, or other health care provider for the service of maintaining, retrieving, reviewing, preparing, copying and mailing the items produced. Except for copies of X-ray photographs, however, such charges shall not exceed ~~\$50~~ \$0.50 for each page up to 50 pages and ~~\$25~~ \$0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and \$1 per page for copies from microfilm or other micrographic process, plus all postage and shipping costs and a search and handling fee not to exceed \$10.

B. Copies of hospital, nursing facility, physician's, or other health care provider's records or papers shall be furnished within 15 days of receipt of such request to the patient, his attorney, his executor or administrator, or an authorized insurer upon such patient's, attorney's, executor's, administrator's, or authorized insurer's written request, which request shall comply with the requirements of subsection E of § 32.1-127.1:03.

However, copies of a patient's records shall not be furnished to such patient when the patient's treating physician or clinical psychologist, in the exercise of professional judgment, has made a part of the patient's records a written statement that in his opinion the furnishing to or review by the patient of such records would be reasonably likely to endanger the life or physical safety of the patient or another person, or that such health records make reference to a person, other than a health care provider, and the access requested would be reasonably likely to cause substantial harm to such referenced person. In any such case, if requested by the patient or his attorney or authorized insurer, such records shall be furnished within 15 days of the date of such request to the patient's attorney or authorized insurer, rather than to the patient.

If the records are not provided to the patient in accordance with this section, then, if requested by the patient, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the patient's request to either (i) provide a copy of the records to a physician or clinical psychologist of the patient's choice whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating physician or clinical psychologist upon whose opinion the denial is based, who shall, at the patient's expense, make a judgment as to whether to make the records available to the patient or (ii) designate a physician or clinical psychologist, whose licensure, training, and experience, relative to the patient's condition, are at least equivalent to that of the treating

physician or clinical psychologist upon whose opinion the denial is based and who did not participate in the original decision to deny the patient's request for his records, who shall, at the expense of the provider denying access to the patient, review the records and make a judgment as to whether to make the records available to the patient. In either such event, the hospital, nursing facility, physician, or other health care provider denying the request shall comply with the judgment of the reviewing physician or clinical psychologist.

A Except as provided in subsection G, a reasonable charge may be made by the hospital, nursing facility, physician or other health care provider maintaining the records for the cost of the services relating to the maintenance, retrieval, review, and preparation of the copies of the records. Except for copies of X-ray photographs, however, such charges shall not exceed ~~\$.50~~ \$0.50 per page for up to 50 pages and ~~\$.25~~ \$0.25 a page thereafter for copies from paper or other hard copy generated from computerized or other electronic storage, or other photographic, mechanical, electronic, imaging or chemical storage process and \$1 per page for copies from microfilm or other micrographic process, a fee for search and handling, not to exceed \$10, and all postage and shipping costs. Any hospital, nursing facility, physician, or other health care provider receiving such a request from a patient's attorney or authorized insurer shall require a writing signed by the patient confirming the attorney's or authorized insurer's authority to make the request and shall accept a photocopy, facsimile, or other copy of the original signed by the patient as if it were an original.

C. Upon the failure of any hospital, nursing facility, physician, or other health care provider to comply with any written request made in accordance with subsection B within the period of time specified in that subsection and within the manner specified in subsections E and F of § 32.1-127.1:03, the patient, his attorney, his executor or administrator, or authorized insurer may cause a subpoena duces tecum to be issued. The subpoena may be issued (i) upon filing a request therefor with the clerk of the circuit court wherein any eventual suit would be required to be filed, and upon payment of the fees required by subdivision A 18 of § 17.1-275, and fees for service or (ii) by the patient's attorney in a pending civil case in accordance with § 8.01-407 without payment of the fees established in subdivision A 23 of § 17.1-275. A sheriff shall not be required to serve an attorney-issued subpoena that is not issued at least five business days prior to the date production of the record is desired. The subpoena shall be returnable within 20 days of proper service, directing the hospital, nursing facility, physician, or other health care provider to produce and furnish copies of the reports and papers to the clerk who shall then make the same available to the patient, his attorney or authorized insurer. If the court finds that a hospital, nursing facility, physician, or other health care provider willfully refused to comply with a written request made in accordance with subsection B, either by willfully or arbitrarily refusing or by imposing a charge in excess of the reasonable expense of making the copies and processing the request for records, the court may award damages for all expenses incurred by the patient or authorized insurer to obtain such copies, including court costs and reasonable attorney's fees.

D. The provisions of subsections A, B, and C hereof shall apply to any health care provider whose office is located within or without the Commonwealth if the records pertain to any patient who is a party to a cause of action in any court in the Commonwealth of Virginia, and shall apply only to requests made by the patient, his attorney, his executor or administrator, or any authorized insurer, in anticipation of litigation or in the course of litigation.

E. Health care provider, as used in this section, shall have the same meaning as provided in § 32.1-127.1:03 and shall also include an independent medical copy retrieval service contracted to provide the service of retrieving, reviewing, and preparing such copies for distribution.

F. Notwithstanding the authorization to admit as evidence patient records in the form of microphotographs, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412.

G. The provisions of this section governing fees that may be charged by a health care provider whose records are subpoenaed or requested pursuant to this section shall not apply in the case of any request by a patient for his own records, which shall be governed by subsection J of § 32.1-127.1:03. This subsection shall not be construed to affect other provisions of state or federal statute, regulation or any case decision relating to charges by health care providers for copies of records requested by any person other than a patient when requesting his own records pursuant to subsection J of § 32.1-127.1:03.

§ 32.1-127.1:03. Health records privacy.

A. There is hereby recognized an individual's right of privacy in the content of his health records. Health records are the property of the health care entity maintaining them, and, except when permitted by this section or by another provision of state or federal law, no health care entity, or other person working in a health care setting, may disclose an individual's health records.

Health records shall not be removed from the premises where they are maintained without the approval of the health care entity that maintains such health records, except in accordance with a court order or subpoena consistent with subsection C of § 8.01-413 or with this section or in accordance with the regulations relating to change of ownership of health records promulgated by a health regulatory board established in Title 54.1.

No person to whom health records are disclosed shall redisclose or otherwise reveal the health records of an individual, beyond the purpose for which such disclosure was made, without first obtaining the individual's specific authorization to such redisclosure. This redisclosure prohibition shall not, however, prevent (i) any health care entity that receives health records from another health care entity from making subsequent disclosures as permitted under this section and the federal Department of Health and Human Services regulations relating to privacy of the electronic transmission of data and protected health information promulgated by the United States Department of Health and Human Services as required by the Health Insurance Portability and Accountability Act (HIPAA) (42 U.S.C. § 1320d et seq.) or (ii) any health care entity from furnishing health records and aggregate or other data, from which individually identifying prescription information has been removed, encoded or encrypted, to qualified researchers, including, but not limited to, pharmaceutical manufacturers and their agents or contractors, for purposes of clinical, pharmaco-epidemiological, pharmaco-economic, or other health services research.

B. As used in this section:

"Agent" means a person who has been appointed as an individual's agent under a power of attorney for health care or an advance directive under the Health Care Decisions Act (§ 54.1-2981 et seq.).

"Certification" means a written representation that is delivered by hand, by first-class mail, by overnight delivery service, or by facsimile if the sender obtains a facsimile-machine-generated confirmation reflecting that all facsimile pages were successfully transmitted.

"Guardian" means a court-appointed guardian of the person.

"Health care clearinghouse" means, consistent with the definition set out in 45 C.F.R. § 160.103, a public or private entity, such as a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that performs either of the following functions: (i) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or (ii) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

"Health care entity" means any health care provider, health plan or health care clearinghouse.

"Health care provider" means those entities listed in the definition of "health care provider" in § 8.01-581.1, except that state-operated facilities shall also be considered health care providers for the purposes of this section. Health care provider shall also include all persons who are licensed, certified, registered or permitted or who hold a multistate licensure privilege issued by any of the health regulatory boards within the Department of Health Professions, except persons regulated by the Board of Funeral Directors and Embalmers or the Board of Veterinary Medicine.

"Health plan" means an individual or group plan that provides, or pays the cost of, medical care. "Health plan" shall include any entity included in such definition as set out in 45 C.F.R. § 160.103.

"Health record" means any written, printed or electronically recorded material maintained by a health care entity in the course of providing health services to an individual concerning the individual and the services provided. "Health record" also includes the substance of any communication made by an individual to a health care entity in confidence during or in connection with the provision of health services or information otherwise acquired by the health care entity about an individual in confidence and in connection with the provision of health services to the individual.

"Health services" means, but shall not be limited to, examination, diagnosis, evaluation, treatment, pharmaceuticals, aftercare, habilitation or rehabilitation and mental health therapy of any kind, as well as payment or reimbursement for any such services.

"Individual" means a patient who is receiving or has received health services from a health care entity.

"Individually identifying prescription information" means all prescriptions, drug orders or any other prescription information that specifically identifies an individual.

"Parent" means a biological, adoptive or foster parent.

C. The provisions of this section shall not apply to any of the following:

1. The status of and release of information governed by §§ 65.2-604 and 65.2-607 of the Virginia Workers' Compensation Act;
2. Except where specifically provided herein, the health records of minors; or
3. The release of juvenile health records to a secure facility or a shelter care facility pursuant to § 16.1-248.3.

D. Health care entities may disclose health records:

1. As set forth in subsection E of this section, pursuant to the written authorization of the individual or in the case of a minor, his custodial parent, guardian or other person authorized to consent to treatment of minors pursuant to § 54.1-2969; also, in emergency cases or situations where it is impractical to obtain an individual's written authorization, pursuant to the individual's oral authorization for a health care provider or health plan to discuss the individual's health records with a third party specified by the individual;

2. In compliance with a subpoena issued in accord with subsection H of this section, pursuant to court order upon good cause shown or in compliance with a subpoena issued pursuant to subsection C of § 8.01-413;

3. In accord with subsection F of § 8.01-399 including, but not limited to, situations where disclosure is reasonably necessary to establish or collect a fee or to defend a health care entity or the health care entity's employees or staff against any accusation of wrongful conduct; also as required in the course of an investigation, audit, review or proceedings regarding a health care entity's conduct by a duly authorized law-enforcement, licensure, accreditation, or professional review entity;

4. In testimony in accordance with §§ 8.01-399 and 8.01-400.2;

5. In compliance with the provisions of § 8.01-413;

6. As required or authorized by law relating to public health activities, health oversight activities, serious threats to health or safety, or abuse, neglect or domestic violence, relating to contagious disease, public safety, and suspected child or adult abuse reporting requirements, including, but not limited to, those contained in §§ 32.1-36, 32.1-36.1, 32.1-40, 32.1-41, 32.1-127.1:04, 32.1-276.5, 32.1-283, 32.1-283.1, 37.1-98.2, 53.1-40.10, 54.1-2400.6, 54.1-2400.7, 54.1-2403.3, 54.1-2506, 54.1-2966, 54.1-2966.1, 54.1-2967, 54.1-2968, 63.2-1509 and 63.2-1606;

7. Where necessary in connection with the care of the individual, including in the implementation of a health care provider's routine contact process pursuant to subdivision B 4 of § 32.1-127;

8. In the normal course of business in accordance with accepted standards of practice within the health services setting; however, the maintenance, storage, and disclosure of the mass of prescription dispensing records maintained in a pharmacy registered or permitted in Virginia shall only be accomplished in compliance with §§ 54.1-3410, 54.1-3411 and 54.1-3412;

9. When the individual has waived his right to the privacy of the health records;

10. When examination and evaluation of an individual are undertaken pursuant to judicial or administrative law order, but only to the extent as required by such order;

11. To the guardian ad litem and any attorney representing the respondent in the course of a guardianship proceeding of an adult patient who is the respondent in a proceeding under Article 1.1 (§ 37.1-134.6 et seq.) of Chapter 4 of Title 37.1;

12. To the attorney appointed by the court to represent an individual who is or has been a patient who is the subject of a civil commitment proceeding under § 37.1-67.3 or a judicial authorization for treatment proceeding pursuant to § 37.1-134.21;

13. To the attorney and/or guardian ad litem of a minor who represents such minor in any judicial or administrative proceeding, if the court or administrative hearing officer has entered an order granting the attorney or guardian ad litem this right and such attorney or guardian ad litem presents evidence to the health care entity of such order;

14. With regard to the Court-Appointed Special Advocate (CASA) program, a minor's health records in accord with § 9.1-156;

15. To an agent appointed under an individual's power of attorney or to an agent or decision maker designated in an individual's advance directive for health care or for decisions on anatomical gifts and organ, tissue or eye donation or to any other person consistent with the provisions of the Health Care Decisions Act (§ 54.1-2981 et seq.);

16. To third-party payors and their agents for purposes of reimbursement;

17. As is necessary to support an application for receipt of health care benefits from a governmental agency or as required by an authorized governmental agency reviewing such application or reviewing benefits already provided or as necessary to the coordination of prevention and control of disease, injury, or disability and delivery of such health care benefits pursuant to § 32.1-127.1:04;

18. Upon the sale of a medical practice as provided in § 54.1-2405; or upon a change of ownership or closing of a pharmacy pursuant to regulations of the Board of Pharmacy;

19. In accord with subsection B of § 54.1-2400.1, to communicate an individual's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;

20. To the individual who is the subject of the health record, except as provided in subsections E and F of this section and subsection B of § 8.01-413;

21. In the case of substance abuse records, when permitted by and in conformity with requirements of federal law found in 42 U.S.C. § 290dd-2 and 42 C.F.R. Part 2;

22. In connection with the work of any entity established as set forth in § 8.01-581.16 to evaluate the adequacy or quality of professional services or the competency and qualifications for professional staff privileges;

23. If the health records are those of a deceased or mentally incapacitated individual to the personal representative or executor of the deceased individual or the legal guardian or committee of the incompetent or incapacitated individual or if there is no personal representative, executor, legal guardian or committee appointed, to the following persons in the following order of priority: a spouse, an adult son or daughter, either parent, an adult brother or sister, or any other relative of the deceased individual in order of blood relationship;

24. For the purpose of conducting record reviews of inpatient hospital deaths to promote

identification of all potential organ, eye, and tissue donors in conformance with the requirements of applicable federal law and regulations, including 42 C.F.R. § 482.45, (i) to the health care provider's designated organ procurement organization certified by the United States Health Care Financing Administration and (ii) to any eye bank or tissue bank in Virginia certified by the Eye Bank Association of America or the American Association of Tissue Banks;

25. To the Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services pursuant to Chapter 16 (§ 37.1-255 et seq.) of Title 37.1;

26. (Expires July 1, 2006) To an entity participating in the activities of a local health partnership authority established pursuant to Article 6.1 (§ 32.1-122.10:001 et seq.) of Chapter 4 of this title, pursuant to subdivision D 1 of this section;

27. To law-enforcement officials by each licensed emergency medical services agency, (i) when the individual is the victim of a crime or (ii) when the individual has been arrested and has received emergency medical services or has refused emergency medical services and the health records consist of the prehospital patient care report required by § 32.1-116.1;

28. To the State Health Commissioner pursuant to § 32.1-48.015 when such records are those of a person or persons who are subject to an order of quarantine or an order of isolation pursuant to Article 3.02 (§ 32.1-48.05 et seq.) of Chapter 2 of this title; and

29. To the Commissioner of the Department of Labor and Industry or his designee by each licensed emergency medical services agency when the records consist of the prehospital patient care report required by § 32.1-116.1 and the patient has suffered an injury or death on a work site while performing duties or tasks that are within the scope of his employment.

E. Requests for copies of health records shall (i) be in writing, dated and signed by the requester; (ii) identify the nature of the information requested; and (iii) include evidence of the authority of the requester to receive such copies and identification of the person to whom the information is to be disclosed. The health care entity shall accept a photocopy, facsimile, or other copy of the original signed by the requester as if it were an original. Within 15 days of receipt of a request for copies of health records, the health care entity shall do one of the following: (i) furnish such copies to any requester authorized to receive them; (ii) inform the requester if the information does not exist or cannot be found; (iii) if the health care entity does not maintain a record of the information, so inform the requester and provide the name and address, if known, of the health care entity who maintains the record; or (iv) deny the request (a) under subsection F, (b) on the grounds that the requester has not established his authority to receive such health records or proof of his identity, or (c) as otherwise provided by law. Procedures set forth in this section shall apply only to requests for health records not specifically governed by other provisions of this Code, federal law or state or federal regulation.

F. Except as provided in subsection B of § 8.01-413, copies of an individual's health records shall not be furnished to such individual or anyone authorized to act on the individual's behalf when the individual's treating physician or the individual's treating clinical psychologist has made a part of the individual's record a written statement that, in the exercise of his professional judgment, the furnishing to or review by the individual of such health records would be reasonably likely to endanger the life or physical safety of the individual or another person, or that such health record makes reference to a person other than a health care provider and the access requested would be reasonably likely to cause substantial harm to such referenced person. If any health care entity denies a request for copies of health records based on such statement, the health care entity shall inform the individual of the individual's right to designate, in writing, at his own expense, another reviewing physician or clinical psychologist, whose licensure, training and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose opinion the denial is based. The designated reviewing physician or clinical psychologist shall make a judgment as to whether to make the health record available to the individual.

The health care entity denying the request shall also inform the individual of the individual's right to request in writing that such health care entity designate, at its own expense, a physician or clinical psychologist, whose licensure, training, and experience relative to the individual's condition are at least equivalent to that of the physician or clinical psychologist upon whose professional judgment the denial is based and who did not participate in the original decision to deny the health records, who shall make a judgment as to whether to make the health record available to the individual. The health care entity shall comply with the judgment of the reviewing physician or clinical psychologist. The health care entity shall permit copying and examination of the health record by such other physician or clinical psychologist designated by either the individual at his own expense or by the health care entity at its expense.

Any health record copied for review by any such designated physician or clinical psychologist shall be accompanied by a statement from the custodian of the health record that the individual's treating physician or clinical psychologist determined that the individual's review of his health record would be reasonably likely to endanger the life or physical safety of the individual or would be reasonably likely to cause substantial harm to a person referenced in the health record who is not a health care provider.

G. A written authorization to allow release of an individual's health records shall substantially include

the following information:

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Individual's Name
Health Care Entity's Name
Person, Agency, or Health Care Entity to whom disclosure is to be made
Information or Health Records to be disclosed
Purpose of Disclosure or at the Request of the Individual

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization unless the specific circumstances under which such conditioning is permitted by law are applicable and are set forth in this authorization. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records. I understand that health information disclosed under this authorization might be redisclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

This authorization expires on (date) or (event)
Signature of Individual or Individual's Legal Representative if Individual is Unable to Sign
.....
Relationship or Authority of Legal Representative
Date of Signature

H. Pursuant to this subsection:

1. Unless excepted from these provisions in subdivision 9, no party to a civil, criminal or administrative action or proceeding shall request the issuance of a subpoena duces tecum for another party's health records or cause a subpoena duces tecum to be issued by an attorney unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the other party's counsel or to the other party if pro se, simultaneously with filing the request or issuance of the subpoena. No party to an action or proceeding shall request or cause the issuance of a subpoena duces tecum for the health records of a nonparty witness unless a copy of the request for the subpoena or a copy of the attorney-issued subpoena is provided to the nonparty witness simultaneously with filing the request or issuance of the attorney-issued subpoena.

No subpoena duces tecum for health records shall set a return date earlier than 15 days from the date of the subpoena except by order of a court or administrative agency for good cause shown. When a court or administrative agency directs that health records be disclosed pursuant to a subpoena duces tecum earlier than 15 days from the date of the subpoena, a copy of the order shall accompany the subpoena.

Any party requesting a subpoena duces tecum for health records or on whose behalf the subpoena duces tecum is being issued shall have the duty to determine whether the individual whose health records are being sought is pro se or a nonparty.

In instances where health records being subpoenaed are those of a pro se party or nonparty witness, the party requesting or issuing the subpoena shall deliver to the pro se party or nonparty witness together with the copy of the request for subpoena, or a copy of the subpoena in the case of an attorney-issued subpoena, a statement informing them of their rights and remedies. The statement shall include the following language and the heading shall be in boldface capital letters:

NOTICE TO INDIVIDUAL

The attached document means that (insert name of party requesting or causing issuance of the subpoena) has either asked the court or administrative agency to issue a subpoena or a subpoena has been issued by the other party's attorney to your doctor, other health care providers (names of health care providers inserted here) or other health care entity (name of health care entity to be inserted here) requiring them to produce your health records. Your doctor, other health care provider or other health care entity is required to respond by providing a copy of your health records. If you believe your health records should not be disclosed and object to their disclosure, you have the right to file a motion with the clerk of the court or the administrative agency to quash the subpoena. If you elect to file a motion to quash, such motion must be filed within 15 days of the date of the request or of the attorney-issued subpoena. You may contact the clerk's office or the administrative agency to determine the requirements that must be satisfied when filing a motion to quash and you may elect to contact an attorney to represent your interest. If you elect to file a motion to quash, you must notify your doctor, other health care provider(s), or other health care entity, that you are filing the motion so that the health care provider or health care entity knows to send the health records to the clerk of court or administrative agency in a sealed envelope or package for safekeeping while your motion is decided.

2. Any party filing a request for a subpoena duces tecum or causing such a subpoena to be issued for an individual's health records shall include a Notice in the same part of the request in which the recipient of the subpoena duces tecum is directed where and when to return the health records. Such notice shall be in boldface capital letters and shall include the following language:

NOTICE TO HEALTH CARE ENTITIES

A COPY OF THIS SUBPOENA DUCES TECUM HAS BEEN PROVIDED TO THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED OR HIS COUNSEL. YOU OR THAT INDIVIDUAL HAS THE RIGHT TO FILE A MOTION TO QUASH (OBJECT TO) THE ATTACHED SUBPOENA. IF YOU ELECT TO FILE A MOTION TO QUASH, YOU MUST FILE THE MOTION WITHIN 15 DAYS OF THE DATE OF THIS SUBPOENA.

YOU MUST NOT RESPOND TO THIS SUBPOENA UNTIL YOU HAVE RECEIVED WRITTEN CERTIFICATION FROM THE PARTY ON WHOSE BEHALF THE SUBPOENA WAS ISSUED THAT THE TIME FOR FILING A MOTION TO QUASH HAS ELAPSED AND THAT:

NO MOTION TO QUASH WAS FILED; OR

ANY MOTION TO QUASH HAS BEEN RESOLVED BY THE COURT OR THE ADMINISTRATIVE AGENCY AND THE DISCLOSURES SOUGHT ARE CONSISTENT WITH SUCH RESOLUTION.

IF YOU RECEIVE NOTICE THAT THE INDIVIDUAL WHOSE HEALTH RECORDS ARE BEING REQUESTED HAS FILED A MOTION TO QUASH THIS SUBPOENA, OR IF YOU FILE A MOTION TO QUASH THIS SUBPOENA, YOU MUST SEND THE HEALTH RECORDS ONLY TO THE CLERK OF THE COURT OR ADMINISTRATIVE AGENCY THAT ISSUED THE SUBPOENA OR IN WHICH THE ACTION IS PENDING AS SHOWN ON THE SUBPOENA USING THE FOLLOWING PROCEDURE:

PLACE THE HEALTH RECORDS IN A SEALED ENVELOPE AND ATTACH TO THE SEALED ENVELOPE A COVER LETTER TO THE CLERK OF COURT OR ADMINISTRATIVE AGENCY WHICH STATES THAT CONFIDENTIAL HEALTH RECORDS ARE ENCLOSED AND ARE TO BE HELD UNDER SEAL PENDING A RULING ON THE MOTION TO QUASH THE SUBPOENA. THE SEALED ENVELOPE AND THE COVER LETTER SHALL BE PLACED IN AN OUTER ENVELOPE OR PACKAGE FOR TRANSMITTAL TO THE COURT OR ADMINISTRATIVE AGENCY.

3. Upon receiving a valid subpoena duces tecum for health records, health care entities shall have the duty to respond to the subpoena in accordance with the provisions of subdivisions 4, 5, 6, 7, and 8.

4. Except to deliver to a clerk of the court or administrative agency subpoenaed health records in a sealed envelope as set forth, health care entities shall not respond to a subpoena duces tecum for such health records until they have received a certification as set forth in subdivisions 5 or 8 of this subsection from the party on whose behalf the subpoena duces tecum was issued.

If the health care entity has actual receipt of notice that a motion to quash the subpoena has been filed or if the health care entity files a motion to quash the subpoena for health records, then the health care entity shall produce the health records, in a securely sealed envelope, to the clerk of the court or administrative agency issuing the subpoena or in whose court or administrative agency the action is pending. The court or administrative agency shall place the health records under seal until a determination is made regarding the motion to quash. The securely sealed envelope shall only be opened on order of the judge or administrative agency. In the event the court or administrative agency grants the motion to quash, the health records shall be returned to the health care entity in the same sealed envelope in which they were delivered to the court or administrative agency. In the event that a judge or administrative agency orders the sealed envelope to be opened to review the health records in camera, a copy of the order shall accompany any health records returned to the health care entity. The health records returned to the health care entity shall be in a securely sealed envelope.

5. If no motion to quash is filed within 15 days of the date of the request or of the attorney-issued subpoena, the party on whose behalf the subpoena was issued shall have the duty to certify to the subpoenaed health care entity that the time for filing a motion to quash has elapsed and that no motion to quash was filed. Any health care entity receiving such certification shall have the duty to comply with the subpoena duces tecum by returning the specified health records by either the return date on the subpoena or five days after receipt of the certification, whichever is later.

6. In the event that the individual whose health records are being sought files a motion to quash the subpoena, the court or administrative agency shall decide whether good cause has been shown by the discovering party to compel disclosure of the individual's health records over the individual's objections. In determining whether good cause has been shown, the court or administrative agency shall consider (i) the particular purpose for which the information was collected; (ii) the degree to which the disclosure of the records would embarrass, injure, or invade the privacy of the individual; (iii) the effect of the disclosure on the individual's future health care; (iv) the importance of the information to the lawsuit or proceeding; and (v) any other relevant factor.

7. Concurrent with the court or administrative agency's resolution of a motion to quash, if subpoenaed health records have been submitted by a health care entity to the court or administrative

agency in a sealed envelope, the court or administrative agency shall: (i) upon determining that no submitted health records should be disclosed, return all submitted health records to the health care entity in a sealed envelope; (ii) upon determining that all submitted health records should be disclosed, provide all the submitted health records to the party on whose behalf the subpoena was issued; or (iii) upon determining that only a portion of the submitted health records should be disclosed, provide such portion to the party on whose behalf the subpoena was issued and return the remaining health records to the health care entity in a sealed envelope.

8. Following the court or administrative agency's resolution of a motion to quash, the party on whose behalf the subpoena duces tecum was issued shall have the duty to certify in writing to the subpoenaed health care entity a statement of one of the following:

a. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution; and, therefore, the health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will not be returned to the health care entity;

b. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are consistent with such resolution and that, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall comply with the subpoena duces tecum by returning the health records designated in the subpoena by the return date on the subpoena or five days after receipt of certification, whichever is later;

c. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution; therefore, no health records shall be disclosed and all health records previously delivered in a sealed envelope to the clerk of the court or administrative agency will be returned to the health care entity;

d. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and that only limited disclosure has been authorized. The certification shall state that only the portion of the health records as set forth in the certification, consistent with the court or administrative agency's ruling, shall be disclosed. The certification shall also state that health records that were previously delivered to the court or administrative agency for which disclosure has been authorized will not be returned to the health care entity; however, all health records for which disclosure has not been authorized will be returned to the health care entity; or

e. All filed motions to quash have been resolved by the court or administrative agency and the disclosures sought in the subpoena duces tecum are not consistent with such resolution and, since no health records have previously been delivered to the court or administrative agency by the health care entity, the health care entity shall return only those health records specified in the certification, consistent with the court or administrative agency's ruling, by the return date on the subpoena or five days after receipt of the certification, whichever is later.

A copy of the court or administrative agency's ruling shall accompany any certification made pursuant to this subdivision.

9. The provisions of this subsection have no application to subpoenas for health records requested under § 8.01-413, or issued by a duly authorized administrative agency conducting an investigation, audit, review or proceedings regarding a health care entity's conduct.

The provisions of this subsection shall apply to subpoenas for the health records of both minors and adults.

Nothing in this subsection shall have any effect on the existing authority of a court or administrative agency to issue a protective order regarding health records, including, but not limited to, ordering the return of health records to a health care entity, after the period for filing a motion to quash has passed.

A subpoena for substance abuse records must conform to the requirements of federal law found in 42 C.F.R. Part 2, Subpart E.

I. Health care entities may testify about the health records of an individual in compliance with §§ 8.01-399 and 8.01-400.2.

J. If an individual requests a copy of his health record from a health care entity, the health care entity may impose a reasonable cost-based fee, which shall include only the cost of supplies for and labor of copying the requested information, postage when the individual requests that such information be mailed, and preparation of an explanation or summary of such information as agreed to by the individual. For the purposes of this section, "individual" shall subsume a person with authority to act on behalf of the individual who is the subject of the health record in making decisions related to his health care.

§ 54.1-111. Unlawful acts; prosecution; proceedings in equity; civil penalty.

A. It shall be unlawful for any person, partnership, corporation or other entity to engage in any of the following acts:

1. Practicing a profession or occupation without holding a valid license as required by statute or regulation.

2. Making use of any designation provided by statute or regulation to denote a standard of professional or occupational competence without being duly certified or licensed.

3. Making use of any titles, words, letters or abbreviations which may reasonably be confused with a designation provided by statute or regulation to denote a standard of professional or occupational competence without being duly certified or licensed.

4. Performing any act or function which is restricted by statute or regulation to persons holding a professional or occupational license or certification, without being duly certified or licensed.

5. Failing to register as a practitioner of a profession or occupation as required by statute or regulation.

6. Materially misrepresenting facts in an application for licensure, certification or registration.

7. Willfully refusing to furnish a regulatory board information or records required or requested pursuant to statute or regulation.

8. Violating any statute or regulation governing the practice of any profession or occupation regulated pursuant to this title.

9. Refusing to process a request, tendered in accordance with the regulations of the relevant health regulatory board or applicable statutory law, for patient records or prescription dispensing records after the closing of a business or professional practice or the transfer of ownership of a business or professional practice.

Any person who willfully engages in any unlawful act enumerated in this section shall be guilty of a Class 1 misdemeanor. The third or any subsequent conviction for violating this section during a 36-month period shall constitute a Class 6 felony.

B. In addition to the criminal penalties provided for in subsection A, the Department of Professional and Occupational Regulation or the Department of Health Professions, without compliance with the Administrative Process Act (§ 2.2-4000 et seq.), shall have the authority to enforce the provisions of subsection A and may institute proceedings in equity to enjoin any person, partnership, corporation or any other entity from engaging in any unlawful act enumerated in this section and to recover a civil penalty of at least \$200 but not more than \$5,000 per violation, with each unlawful act constituting a separate violation; but in no event shall the civil penalties against any one person, partnership, corporation or other entity exceed \$25,000 per year. Such proceedings shall be brought in the name of the Commonwealth by the appropriate Department in the circuit court or general district court of the city or county in which the unlawful act occurred or in which the defendant resides.

C. This section shall not be construed to prohibit or prevent the owner of patient records from (i) retaining copies of his patient records or prescription dispensing records after the closing of a business or professional practice or the transfer of ownership of a business or professional practice or (ii) charging a reasonable fee, ~~not in excess of the amounts authorized~~ in accordance with subsections A and B of § 8.01-413 or subsection J of § 32.1-127.1:03, for copies of patient records, as applicable under the circumstances.

D. This section shall apply, mutatis mutandis, to all persons holding a multistate licensure privilege to practice nursing in the Commonwealth of Virginia.

HOUSE JOINT RESOLUTION NO. 701

Encouraging the Commissioner of the Department for the Aging and the Commissioner of the State Department of Health to provide information on wrap-around coverage offered by some pharmaceutical companies for low-income Medicare beneficiaries.

Agreed to by the House of Delegates, February 5, 2005
Agreed to by the Senate, February 24, 2005

WHEREAS, in fulfillment of its responsibility pursuant to the second enactment clause of House Bill No. 2225 (2003) and Senate Bill No. 1341 (2003), the Joint Commission on Health Care approved the Healthy Lives Prescription Plan that included monitoring the actions of Congress regarding the creation of a prescription drug benefit under Medicare and encouraging partnerships with community-based organizations; and

WHEREAS, pursuant to § 32.1-23.1 of the Code of Virginia, the Commissioner of the Department for the Aging and the Commissioner of the State Department of Health are directed to "coordinate the dissemination of information to the public regarding any pharmaceutical discount purchasing card programs" and "shall disseminate information to the public concerning recent congressional actions relating to pharmaceutical benefits to be provided under the Medicare program"; and

WHEREAS, the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Medicare prescription drug discount card program to provide discounts for prescription medications beginning in June of 2004 and continuing until the implementation of the full Medicare prescription drug benefit in January of 2006; and

WHEREAS, in addition to the potential savings available through the Medicare discount card program, certain low-income beneficiaries may also be eligible for transitional assistance in the form of a \$600 credit for the purchase of prescription drugs in 2004 and an additional \$600 credit in 2005; and

WHEREAS, several prescription drug manufacturers are providing additional "wrap-around" assistance to qualified low-income Medicare beneficiaries enrolled in the Medicare prescription drug discount card program who have exhausted their \$600 transitional assistance credit; and

WHEREAS, the Virginia Department for the Aging, with assistance from the State Department of Health, has served as the primary conduit of information for seniors about pharmaceutical programs pursuant to § 32.1-23.1; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Commissioner of the Department for the Aging and the Commissioner of the State Department of Health be encouraged to provide information on wrap-around coverage offered by some pharmaceutical companies for low-income Medicare beneficiaries; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit a copy of this resolution to the Commissioner of the Department for the Aging and the Commissioner of the State Department of Health, requesting that the Commissioners further disseminate copies of this resolution to their respective constituents so that they may be apprised of the sense of the General Assembly of Virginia in this matter.

ENROLLED

HJ701ER

HOUSE JOINT RESOLUTION NO. 702

Encouraging the Department for the Aging, the Department of Medical Assistance Services, and the State Department of Health to consult with the Virginia Dental Association and the Virginia Health Care Foundation on the feasibility of disseminating certain information on prescription assistance programs and prescription drug discount cards.

Agreed to by the House of Delegates, February 5, 2005
Agreed to by the Senate, February 24, 2005

WHEREAS, in fulfillment of its responsibility pursuant to the second enactment clause of House Bill No. 2225 (2003) and Senate Bill No. 1341 (2003), the Joint Commission on Health Care approved the Healthy Lives Prescription Plan that included monitoring the actions of Congress regarding the creation of a prescription drug benefit under Medicare and encouraging partnerships with community-based organizations; and

WHEREAS, the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Medicare prescription drug discount card program to provide discounts for prescription medications beginning in June of 2004 and continuing until the implementation of the full Medicare prescription drug benefit in January of 2006; and

WHEREAS, the Medicare prescription drug discount card program is difficult to understand without supplemental explanatory information; and

WHEREAS, low-income citizens of the Commonwealth are in need of such information concerning this program; and

WHEREAS, through patient assistance programs and prescription drug discount cards, private pharmaceutical manufacturers are currently providing assistance to individuals with low incomes who lack pharmaceutical coverage; and

WHEREAS, the Mission of Mercy program sponsored by the Virginia Dental Association and the Virginia Health Care Foundation in partnership with a number of organizations provides free dental care services to Virginians in underserved areas of the state; and

WHEREAS, the Mission of Mercy program voluntarily provides information on a variety of community and health services; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department for the Aging, the Department of Medical Assistance Services, and the State Department of Health be encouraged to consult with the Virginia Dental Association and the Virginia Health Care Foundation on the feasibility of disseminating certain information on prescription assistance programs and prescription drug discount cards. The Departments shall cooperate with the Virginia Dental Association and the Virginia Health Care Foundation and its partnering organizations in exploring the feasibility of using the Mission of Mercy program to disseminate information concerning prescription assistance programs and Medicare prescription drug discount cards; and, be it

RESOLVED FURTHER, That the Clerk of the House of Delegates transmit a copy of this resolution to the Commissioner of the Department for the Aging, the Director of the Department of Medical Assistance Services, the Commissioner of the State Department of Health, the Executive Director of the Virginia Dental Association, and the Executive Director of the Virginia Health Care Foundation, requesting that these officials further disseminate copies of this resolution to their respective constituents so that they may be apprised of the sense of the General Assembly of Virginia in this matter.

ENROLLED

HJ702ER

2005 SESSION

ENROLLED

SENATE JOINT RESOLUTION NO. 363

Encouraging the Department for the Aging, the Department of Medical Assistance Services, and the Department of Health to consult with the Virginia Dental Association and the Virginia Health Care Foundation on the feasibility of disseminating certain information on prescription assistance programs and prescription drug discount cards.

Agreed to by the Senate, February 25, 2005

Agreed to by the House of Delegates, February 24, 2005

WHEREAS, in fulfillment of its responsibility pursuant to the second enactment clause of House Bill No. 2225 (2003) and Senate Bill No. 1341 (2003), the Joint Commission on Health Care approved the Healthy Lives Prescription Plan that included monitoring the actions of Congress regarding the creation of a prescription drug benefit under Medicare and encouraging partnerships with community-based organizations; and

WHEREAS, the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Medicare prescription drug discount card program to provide discounts for prescription medications beginning in June of 2004 and continuing until the implementation of the full Medicare prescription drug benefit in January of 2006; and

WHEREAS, the Medicare prescription drug discount card program is difficult to understand without supplemental explanatory information; and

WHEREAS, low-income citizens of the Commonwealth are in need of such information concerning this program; and

WHEREAS, through patient assistance programs and prescription drug discount cards, private pharmaceutical manufacturers are currently providing assistance to individuals with low incomes who lack pharmaceutical coverage; and

WHEREAS, the Mission of Mercy program sponsored by the Virginia Dental Association and the Virginia Health Care Foundation in partnership with a number of organizations provides free dental care services to Virginians in underserved areas of the state; and

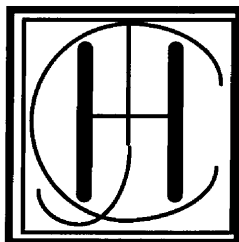
WHEREAS, the Mission of Mercy program voluntarily provides information on a variety of community and health services; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department for the Aging, the Department of Medical Assistance Services, and the Department of Health be encouraged to consult with the Virginia Dental Association and the Virginia Health Care Foundation on the feasibility of disseminating certain information on prescription assistance and prescription discount cards. The Departments shall cooperate with the Virginia Dental Association and the Virginia Health Care Foundation and its partnering organizations in exploring the feasibility of using the Mission of Mercy program to disseminate information concerning prescription assistance programs and Medicare prescription drug discount cards; and, be it

RESOLVED FURTHER, That the Clerk of the Senate transmit a copy of this resolution to the Commissioner of the Department for the Aging, the Director of the Department of Medical Assistance Services, the Commissioner of Health, the Executive Director of the Virginia Dental Association, and the Executive Director of the Virginia Health Care Foundation, requesting that these officials further disseminate copies of this resolution to their respective constituents so that they may be apprised of the sense of the General Assembly of Virginia in this matter.

ENROLLED

SJ363ER



Joint Commission on Health Care
900 East Main Street, Suite 3072E
P.O. Box 1322
Richmond, Virginia 23218
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

<http://legis.state.va.us/jchc/jchchome.htm>