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HOUSE BILL NO. 2155

Offered January 10, 2001
Prefiled January 10, 2001

A BILL to amend and reenact §§ 2.1-394, 32.1-102.1, 32.1-102.12, 32.1-276.3, and 32.1-276.5 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.01 and an article numbered 1.3 in Chapter 5 of Title 32.1, consisting of sections numbered 32.1-137.18 and 32.1-137.19, and to repeal § 32.1-102.1:1, all relating to regulation of health care facilities.

Patrons—Morgan, Brink, Bryant, Diamonstein, Hall and Hamilton; Senator: Bolling

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 1.1 of Chapter 4 of Title 32.1 a section numbered 32.1-102.01 as follows:

§ 32.1-102.01. Three-phased plan for deregulation of certain medical care facilities' certificate of public need services; goals; components of plan.

A. As required by § 32.1-102.13, the deregulation of certain certificate of public need services, equipment, and facilities shall be accomplished in accordance with the three-phased plan adopted by the Joint Commission on Health Care and published in December 2000, hereinafter referred to as "the Plan."

B. Goals of the Plan shall be to:

1. Offer more choices to patients while simultaneously providing consumers with better information about the value of services in all settings;

2. Ensure that access to essential health care services for all Virginians, particularly the indigent and the uninsured, is preserved and improved, in so far as possible;

3. Provide strong quality protections that correspond to service intensity and patient risk and apply similarly across all health care settings;

4. Support indigent care and medical education costs at the academic health centers; and

5. Ensure that the Commonwealth's health care financing programs reimburse at a level that covers the allowable costs of care and that the Commonwealth meets its obligations as a responsible business partner.

C. The Plan for certificate of public need deregulation required by § 32.1-102.13 and adopted by the Joint Commission on Health Care shall be contingent upon the appropriation of relevant funding and shall consist of three phases as follows:

1. Phase I deregulated services, equipment, and facilities shall be computed tomographic (CT) scanning, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, and all nuclear medicine imaging pursuant to § 32.1-102.1.

The providers of the Phase I deregulated services shall be required to comply with licensure requirements promulgated and administered by the Board of Health, pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of Title 32.1, that shall be applied equally across all health care settings, consistent with appropriate existing, nationally recognized accreditation standards. Entities that are accredited by national accreditation organizations that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Further, the providers of the Phase I deregulated services shall also be required to report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of this title, claims data, certain quality outcome information for selected high-risk procedures, where applicable, and annual financial information on indigent care.

In addition, pursuant to subsection D of § 2.1-394, codification of Commonwealth policy to fully fund the costs of indigent care at the state-supported academic medical centers, i.e., the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School, shall be included in Phase I.

2. Phase II deregulated services, equipment, and facilities shall be cardiac catheterization, gamma knife surgery, and radiation therapy.

The providers of the Phase II deregulated services shall be required to comply with licensure requirements promulgated and administered by the Board of Health, pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of Title 32.1, that are applied equally across all health care

settings, consistent with appropriate existing, nationally recognized accreditation standards. Entities that are accredited by national accreditation organizations that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Further, the providers of the Phase II deregulated services shall also be required to report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of this title, claims data, certain quality outcome information for selected high risk procedures, where applicable, and annual financial information on indigent care.

3. Phase III deregulated services, equipment, and facilities shall be ambulatory surgery centers, neonatal special care, obstetric services, open-heart surgery, and organ transplantation services.

The providers of phase III deregulated services shall also be required to comply with licensure requirements administered by the Board of Health, pursuant to Article 1.3 (§32.1- 137.18 et seq.) of Chapter 5 of Title 32.1, that are applied equally across all health care settings, consistent with appropriate existing, nationally recognized accreditation standards; for neonatal special care, open-heart surgery, and organ transplantation licensure review shall include a review of the applicant's ability to attract sufficient additional volume within the appropriate service area for the applicant to meet nationally recognized quality thresholds for patient volume.

Entities that are accredited by national accreditation organizations that are accepted by the Board shall be deemed to be in compliance with such licensure requirements.

Further, the providers of Phase III deregulated services shall also be required to report to the Board of Health, pursuant to Chapter 7.2 (§ 32.1-276.2 et seq.) of this title, claims data, certain quality outcome information for selected high-risk procedures, where applicable, and annual financial information on indigent care. The Board of Health shall collect, at appropriate intervals, volume and outcome information from newly deregulated and licensed providers of neonatal special care, open-heart surgery, and organ transplantation.

2. That §§ 2.1-394, 32.1-102.1, 32.1-102.12, 32.1-276.3, and 32.1-276.5 of the Code of Virginia are amended and reenacted and the Code of Virginia is amended by adding an article numbered 1.3 in Chapter 5 of Title 32.1, consisting of sections numbered 32.1-137.18 and 32.1-137.19 as follows:

§ 2.1-394. Estimates by state agencies of amounts needed.

A. Biennially in the odd-numbered years, on a date established by the Governor, each of the several state agencies and other agencies and undertakings receiving or asking financial aid from the Commonwealth shall report to the Governor, through the responsible secretary designated by statute or executive order, in a format prescribed for such purpose, an estimate in itemized form showing the amount needed for each year of the ensuing biennial period beginning with the first day of July thereafter. The Governor may prescribe targets which shall not be exceeded in the official estimate of each agency; however, an agency may submit to the Governor a request for an amount exceeding the target as an addendum to its official budget estimate.

B. Each agency or undertaking required to submit a biennial estimate pursuant to subsection A of this section shall simultaneously submit an estimate of the amount which will be needed for the two succeeding biennial periods beginning July 1 of the third year following the year in which the report is submitted. The Department of Planning and Budget shall provide, within thirty days following receipt, copies of all agency estimates provided under this subsection to the chairmen of the House Committee on Appropriations and the Senate Committee on Finance.

C. The format which must be used in making these reports shall be prescribed by the Governor, shall be uniform for all agencies and shall clearly designate the kind of information to be given thereon. The Governor may prescribe a different format for reports from institutions of higher education, which format shall be uniform for all such institutions and shall clearly designate the kind of information to be provided thereon.

D. It shall be the policy of the Commonwealth to appropriate 100 percent of the costs of the indigent health care services provided by or through the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center. In addition, it shall be the policy of the Commonwealth to fund at least fifty percent of the costs of indigent health care services provided by or through the faculty, students, and associated hospitals of the Eastern Virginia Medical School, operated under the auspices of the Medical College of Hampton Roads as established in Chapter 471 of the Acts of Assembly of 1964, as amended.

The Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center shall submit the estimates of the amounts needed for this purpose in the manner required by this section. The Medical College of Hampton Roads shall submit such data and estimates as shall be required by the Director of the Department of Planning and Budget.

§ 32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative

procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. ~~Sanitariums.~~

~~3.~~ Nursing homes.

~~4~~*3*. Intermediate care facilities.

~~5~~*4*. Extended care facilities.

~~6~~*5*. Mental hospitals.

~~7~~*6*. Mental retardation facilities.

~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

~~9~~*8*. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning,~~ *and* radiation therapy~~, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation~~.

~~10~~*9*. Rehabilitation hospitals.

~~11~~*10*. Any facility licensed as a hospital.

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; or (iv) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of any new cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ medical rehabilitation, neonatal special care, obstetrical *service*, open heart surgery, ~~positron emission tomographic (PET) scanning,~~ psychiatric *service*, organ or tissue transplant service, radiation therapy, ~~nuclear medicine imaging, except for the purpose of nuclear cardiac imaging,~~ *or* substance abuse treatment, ~~or such other specialty clinical services as may be designated by the Board by regulation, which~~ *that* the facility has never provided or has not provided in the previous twelve months;

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds; *or*

7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, ~~computed tomographic (CT) scanning,~~ gamma knife surgery, ~~lithotripsy,~~ ~~magnetic resonance imaging (MRI),~~ ~~magnetic source imaging (MSI),~~ open heart surgery, ~~positron emission tomographic (PET) scanning,~~ *and* radiation therapy~~, or other specialized service designated by the Board by regulation~~. Replacement of existing equipment shall not require a certificate of public need~~; or~~

~~8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant to regulations developed by the Board~~.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 ~~which~~ *that* serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

§ 32.1-102.12. Report required.

The Commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program. The report shall be issued by October 1 of each year and shall include, but need not be limited to:

1. A summary of the Commissioner's actions during the previous fiscal year pursuant to this article;

2. ~~A five-year schedule for analysis of all project categories which provides for analysis of at least three project categories per year;~~

~~3.~~ An analysis*, in conjunction with the Joint Commission on Health Care,* of the appropriateness of continuing the certificate of public need program for ~~at least three~~ *various* project categories in accordance with the ~~five~~ *three*-year schedule for analysis of ~~all~~ *the* project categories;

~~4~~*3*. An analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department required by § 32.1-102.6 which details the review time required during the past year for various project categories, the number of contested or opposed applications and the project categories of these contested or opposed projects, the number of applications upon which the health systems agencies have failed to act in accordance with the timelines of *subsection B of* § 32.1-102.6 ~~B~~, and the number of deemed approvals from the Department because of their failure to comply with the timelines required by *subsection E of* § 32.1-102.6 ~~E~~, and any other data determined by the Commissioner to be relevant to the efficient operation of the program; *and*

~~5~~*4*. An ~~analysis of health care market reform in the Commonwealth~~ *assessment, in conjunction with the Joint Commission on Health Care, of the effects of the deregulation phases, as appropriate, on access to care, particularly access to care by the indigent and uninsured, quality of care and the relevance of certificate of public need to quality care, indigent care costs and access to care, and the issues described in § 32.1-102.13* and the extent, if any, to which such ~~reform obviates~~ *effects obviate* the need for the certificate of public need program~~;~~

~~6. An analysis of the accessibility by the indigent to care provided by the medical care facilities regulated pursuant to this article and the relevance of this article to such access;~~

~~7. An analysis of the relevance of this article to the quality of care provided by medical care facilities regulated pursuant to this article; and~~

~~8. An analysis of equipment registrations required pursuant to § 32.1-102.1:1, including the type of equipment, whether an addition or replacement, and the equipment costs~~.

Article 1.3.

Licensure of Certain Specialty Services.

§ 32.1-137.18. Definitions.

As used in this article:

"Accreditation" means approval by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., or the American College of Radiology, or such other national accrediting organization as may be determined by the Board of Health to have acceptable quality of care standards.

"Board" means the Board of Health.

"Specialty Services" means any specialty service regardless of whether located in an outpatient or inpatient setting that (i) required, on July 1, 2000, a certificate of public need for the purchase of the

relevant equipment, building of the relevant facility or introduction of the relevant service, and (ii) was subsequently deregulated for the purpose of the certificate of public need program in 2001 or thereafter, or (iii) such other specialty services as may be designated by the Board by regulation.

§ 32.1-137.19. Licensure required; Board regulations.

A. No specialty services, regardless of where located, shall operate in this Commonwealth without a license issued by the Board of Health; however, any specialty service already in operation on or before the effective date of the relevant licensure requirement shall not be required to be so licensed until one year after the effective date of the Board's relevant regulations or January 1 of the year following the promulgation and final adoption of the Board's relevant regulations, whichever comes first.

In the case of specialty services operated as part of a general hospital, no separate specialty service license shall be required; however, regardless of whether such service is operated under the general hospital license or a specialty service license, the Board of Health shall ensure that the quality protection licensure requirements correspond to service intensity or risk and remain consistent across all settings.

B. The Board of Health shall promulgate regulations to grant and renew specialty service licenses in accordance with this article. The Board's regulations shall include:

1. Virginia licensure standards for the specific specialty service that are consistent with nationally recognized standards for such specialty service.

2. A list of those national accrediting organizations having standards acceptable for licensure in Virginia, including, but not limited to, the Joint Commission on Accreditation of Health Care organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology.

3. Procedures for periodic inspection of specialty services that avoid redundant site visits and coordinate or substitute the inspections of the specialty services with any inspections required by another state agency or accreditation organization.

4. Licensure application and renewal forms for specialty services.

5. Licensure fees that are sufficient to cover the costs of the specialty services licensure program.

Licenses issued pursuant to this article shall expire at midnight on December 31 of the year issued, or as otherwise specified by the Board, and shall be required to be renewed annually.

Those providers accredited by the Joint Commission on Accreditation of Health Care Organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology or such other national accrediting organization as may be acceptable to the Board shall be deemed to be in compliance with the Virginia licensure standards and shall be granted a license. Renewal licenses shall also be granted upon proof of maintenance of such accreditation. The Board's regulations shall condition initial licensure on the satisfactory completion of minimum training and experience requirements for physicians and other health care personnel that are consistent with such national accreditation standards; however, the Board's regulations shall not condition initial licensure of such specialty services on any minimum amount of experience or patient volume at a particular facility.

C. Licensure of specialty services shall be conditioned on the following requirements: (i) all licensed specialty services providers shall accept all patients regardless of ability to pay; (ii) all such providers shall agree to become participating providers in the Virginia Medicaid program and the Commonwealth's State Children's Health Insurance Program (SCHIP) established pursuant to Title XXI of the Social Security Act and Subtitle J of the federal Balanced Budget Act of 1997 (P.O. 105-33); and (iii) all such providers shall participate and contribute to any new or revised mechanism for funding of indigent health care.

D. No license issued hereunder shall be assignable or transferable.

§ 32.1-276.3. (Effective until July 1, 2003) Definitions.

As used in this chapter:

"Board" means the Board of Health.

"Consumer" means any person (i) whose occupation is other than the administration of health activities or the provision of health services, (ii) who has no fiduciary obligation to a health care institution or other health agency or to any organization, public or private, whose principal activity is an adjunct to the provision of health services, or (iii) who has no material financial interest in the rendering of health services.

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice

medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; ~~or~~ (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2*; or (vii) any person licensed to provide specialty services pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of this title*. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

"Health maintenance organization" means any person who undertakes to provide or to arrange for one or more health care plans pursuant to Chapter 43 (§ 38.2-4300 et seq.) of Title 38.2.

"Inpatient hospital" means a hospital providing inpatient care and licensed pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title, a hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1, a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services for the care and treatment of the mentally ill, or a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority.

"Nonprofit organization" means a nonprofit, tax-exempt health data organization with the characteristics, expertise, and capacity to execute the powers and duties set forth for such entity in this chapter.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.5. (Effective until July 1, 2003) Providers to submit data.

A. Every health care provider shall submit data as required pursuant to regulations of the Board, consistent with the recommendations of the nonprofit organization in its strategic plans submitted and approved pursuant to § 32.1-276.4, and as required by this section*; however, specialty services providers licensed pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of this title shall only be required to submit claims data, quality outcome information for selected high-risk procedures as set forth in the Board's regulations, and annual financial information on indigent care. In addition, the Board shall collect, at appropriate intervals, volume and outcomes data from newly COPN-deregulated and -licensed providers of high-risk and/or complex services as set forth in its regulations.* Notwithstanding the provisions of Chapter 26 (§ 2.1-377 et seq.) of Title 2.1, it shall be lawful to provide information in compliance with the provisions of this chapter.

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

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

D. The Board shall evaluate biennially the impact and effectiveness of such data collection.

3. That the provisions of the second enactment comprise the components of Phase I of the Plan adopted by and published in December 2000 by the Joint Commission on Health Care pursuant to § 32.1-102.13.

4. That the provisions of the second enactment shall only become effective upon the inclusion in the appropriations act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) fund the initial phase of improving the adequacy of Medicaid hospital reimbursement, as recommended by the Joint Legislative Audit and Review Commission in 2000; and (iii) fund the initial phase of funding to replace the use of clinical revenues in supporting the core costs of undergraduate medical education.

5. That, further, upon the enactment of an appropriation act including the funding described in the fourth enactment: (i) the purchase of equipment or other capital investment necessary to plan and operate a specialty service that is to be deregulated pursuant to the second enactment shall be authorized; however, no such specialty service shall initiate operation prior to the promulgation of

and compliance with the licensure requirements set forth in Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of Title 32.1; (ii) the Board of Health shall promulgate regulations to implement the relevant licensure provisions of the second enactment of this act within 280 days of the date of the enactment of the relevant appropriation act; (iii) the Board of Health shall assemble, to facilitate the implementation of the second enactment, an advisory certificate of public need deregulation taskforce that shall, at minimum, include representatives of the Medical Society of Virginia, the Virginia Health Care Association, and the Virginia Hospital and Healthcare Association, and representatives of such other health care organizations as may desire representation, particularly those who participated in development of the Plan with the Joint Commission on Health Care; and (iv) the advisory certificate of public need deregulation taskforce shall advise and assist the Board and Department of Health in the development of the licensure regulations for COPN-deregulated specialty services during the three phases of deregulation and until completion of the three-phased plan developed by the Joint Commission on Health Care.

6. That, in addition, and notwithstanding the effective date of the second enactment, during Phase I, the Joint Legislative Audit and Review Commission shall examine and make recommendations for revision of the Medicaid physician payment systems across all specialties.

7. That, notwithstanding the effective date of the second enactment, during Phase I, the Joint Commission on Health Care shall: (i) evaluate relevant data collection proposals and regulatory initiatives; (ii) monitor the effects of Phase I on access to care, quality of care, indigent care costs and all issues described in § 32.1-102.13; (iii) study options for coverage of low-income adult parents having incomes of 100 to 200 percent of federal poverty level under Virginia's State Children's Health Insurance Program pursuant to Title XXI of the Social Security Act and Subtitle J of the federal Balanced Budget Act of 1997 (P.L. 105-33); (iv) work with the Department of Medical Assistance Services to emphasize outreach efforts and streamline enrollment of low-income families in the Virginia Children's Medical Security Insurance Plan or the Family Access to Medical Insurance Security Plan, as appropriate; (v) conduct a survey of uninsured persons in Virginia; (vi) design a proposal for incorporating deregulated services into the Indigent Health Care Trust Fund or a new indigent care program; and (vii) study a possible state component to correspond with the federal critical access hospital program as set forth in the Balanced Budget Act of 1997, P.L. 105-33 and Title XVIII of the Social Security Act, as amended.

8. That § 32.1-102.1 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. ~~Sanitariums.~~

~~3~~. Nursing homes.

~~4~~*3*. Intermediate care facilities.

~~5~~*4*. Extended care facilities.

~~6~~*5*. Mental hospitals.

~~7~~*6*. Mental retardation facilities.

~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

~~9~~*8*. Specialized centers or clinics or that portion of a physician's office developed for the provision of

outpatient or ambulatory surgery~~,~~ ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation~~.

~~10~~*9*. Rehabilitation hospitals.

~~11~~*10*. Any facility licensed as a hospital.

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; or (iv) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of any new ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ medical rehabilitation, neonatal special care, obstetrical *service*, open heart surgery, ~~positron emission tomographic (PET) scanning,~~ psychiatric *service*, organ or tissue transplant service, ~~radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging,~~ *or* substance abuse treatment~~, or such other specialty clinical services as may be designated by the Board by regulation, which~~*that* the facility has never provided or has not provided in the previous twelve months;

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds; *or*

7. The addition by an existing medical care facility of any medical equipment for the provision of ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ open heart surgery~~, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation~~. Replacement of existing equipment shall not require a certificate of public need~~; or~~

~~8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant to regulations developed by the Board~~.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 ~~which~~ *that* serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

9. That the provisions of the eighth enactment comprise the components of Phase II of the Plan adopted by and published in December 2000 by the Joint Commission on Health Care pursuant to § 32.1-102.13.

10. That the provisions of the eighth enactment shall only become effective upon the inclusion in the appropriation act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the

state-supported academic health centers, i.e., the Virginia commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) fund the second phase of improving the adequacy of Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission; (iii) fund the initial phase of the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission in 2000, if applicable; (iv) complete the phased-in funding to replace the use of clinical revenues in funding the core cost of undergraduate medical education; (v) expand phased-in Medicaid coverage for uninsured low-income parents to 66 percent of federal poverty level; (vi) provide a phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 90 percent of federal poverty level; and (vii) provide the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions.

11. That, further, upon the enactment of an appropriation act including the funding described in the tenth enactment above: (i) the purchase of equipment or other capital investment necessary to plan and operate a specialty service that is to be deregulated pursuant to the eighth enactment shall be authorized; however no such specialty service shall initiate operation prior to the promulgation of and compliance with the licensure requirements set forth in Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of Title 32.1.; (ii) the Board of Health shall promulgate regulations to implement the relevant licensure provisions required by the eighth enactment within 280 days of the date of the enactment of the relevant appropriation act; and (iii) the Board of Health shall continue to assemble, in order to facilitate the implementation of the eighth enactment, the advisory certificate of public need deregulation taskforce that is established in the third enactment of this act.

12. That, notwithstanding the effective date of the eighth enactment, during Phase II, the Joint Commission on Health Care shall: (i) study the issues relating to the support of graduate medical education and the issues relating to state-support of research; (ii) monitor the effects of Phase I and Phase II on access to care, quality of care, indigent care costs, and all issues described in § 32.1-102.13; (iii) study options for coverage of persons having incomes of over 200 percent of federal poverty level; (iv) evaluate the community benefits emanating from and uncompensated care provided by all service delivery sites; and (v) evaluate the appropriateness of revising the definition of and the criteria used for the licensure of ambulatory surgery centers.

13. That § 32.1-102.1 is amended and reenacted as follows:

§ 32.1-102.1. Definitions.

As used in this article, unless the context indicates otherwise:

"Certificate" means a certificate of public need for a project required by this article.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure or a series of such procedures that may be separately identified for billing and accounting purposes.

"Health planning region" means a contiguous geographical area of the Commonwealth with a population base of at least 500,000 persons which is characterized by the availability of multiple levels of medical care services, reasonable travel time for tertiary care, and congruence with planning districts.

"Medical care facility," as used in this title, means any institution, place, building or agency, whether or not licensed or required to be licensed by the Board or the State Mental Health, Mental Retardation and Substance Abuse Services Board, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) which is the recipient of reimbursements from third-party health insurance programs or prepaid medical service plans. For purposes of this article, only the following medical care facilities shall be subject to review:

1. General hospitals.

2. ~~Sanitariums.~~

~~3.~~ Nursing homes.

~~4~~*3*. Intermediate care facilities.

~~5~~*4*. Extended care facilities.

~~6~~*5*. Mental hospitals.

~~7~~*6*. Mental retardation facilities.

~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.

~~9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation.~~

~~10~~*8*. Rehabilitation hospitals.

~~11~~*9*. Any facility licensed as a hospital.

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) ~~a physician's office, except that portion of a physician's office described above in subdivision 9 of the definition of "medical care facility"; or (iv)~~ the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

2. An increase in the total number of beds or operating rooms in an existing medical care facility;

3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;

4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;

5. Introduction into an existing medical care facility of any new ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ medical rehabilitation, ~~neonatal special care, obstetrical, open heart surgery, positron emission tomographic (PET) scanning,~~ psychiatric~~, organ or tissue transplant service, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging~~, *or* substance abuse treatment *service*~~, or such other specialty clinical services as may be designated by the Board by regulation, which~~ *that* the facility has never provided or has not provided in the previous twelve months; *or*

6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds~~;~~

~~7. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation. Replacement of existing equipment shall not require a certificate of public need; or~~

~~8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant to regulations developed by the Board~~.

"Regional health planning agency" means the regional agency, including the regional health planning board, its staff and any component thereof, designated by the Virginia Health Planning Board to perform the health planning activities set forth in this chapter within a health planning region.

"State Medical Facilities Plan" means the planning document adopted by the Board of Health which shall include, but not be limited to, (i) methodologies for projecting need for medical care facility beds and services; (ii) statistical information on the availability of medical care facilities and services; and (iii) procedures, criteria and standards for review of applications for projects for medical care facilities and services.

"Virginia Health Planning Board" means the statewide health planning body established pursuant to § 32.1-122.02 ~~which~~ *that* serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

14. That the provisions of the thirteenth enactment comprise the components of Phase III of the Plan adopted and published in December 2000 by the Joint Commission on Health Care pursuant to § 32.1-102.13.

15. That the provisions of the thirteenth enactment shall only become effective upon the inclusion

in the appropriations act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) continue the funding of increased Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission in 2000; (iii) continue funding the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission, if applicable; (iv) continue funding to replace the use of clinical revenues in supporting the core cost of undergraduate medical education; (v) complete the phased-in expansion of Medicaid reimbursement for uninsured low-income parents to 100 percent of federal poverty level; (vi) complete the phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 100 percent of federal poverty level; (vii) Continue the provision of the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions; and (viii) fund the implementation of such recommendations as may be appropriate on graduate medical education and state support for research.

16. That, upon the enactment of an appropriation act including the funding described in the fifteenth enactment: (i) the purchase of equipment or other capital investment necessary to plan and operate a specialty service that is to be deregulated pursuant to the thirteenth enactment shall be authorized; however, no such specialty service shall initiate operation prior to the promulgation of and compliance with the licensure requirements set forth in Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of Title 32.1; (ii) the Board of Health shall promulgate regulations to implement the relevant licensure provisions of the sixth enactment within 280 days of the date of the enactment of such appropriation act; and (iii) the Board of Health shall continue to assemble, in order to facilitate the implementation of the thirteenth enactment, the advisory certificate of public need deregulation taskforce that is established in second enactment of this act.

17. That, notwithstanding the effective date of the thirteenth enactment, during Phase III, the Joint Commission on Health Care shall: (i) monitor the effects of Phase I, Phase II, and Phase III on access to care, quality of care, indigent care costs, and all issues described in § 32.1-102.13; and (ii) reassess the adequacy and equity of long-term care reimbursement in Virginia.

18. That, upon completion of Phase III, the Joint Commission on Health Care shall reassess the efficacy of continuing certificate of public need for the remaining covered services and facilities.

19. That § 32.1-102.1:1 is repealed.