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## HOUSE BILL NO. 2101

House Amendments in [ ] — February 6, 2017

A BILL to amend and reenact §§ 32.1-102.1, 32.1-102.2, 32.1-102.4, and 32.1-276.5 of the Code of Virginia, relating to health care providers; data collection.

Patron Prior to Engrossment—Delegate Byron

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1, 32.1-102.2, 32.1-102.4, and 32.1-276.5 of the Code of Virginia are amended and reenacted as follows:

## § 32.1-102.1. Definitions.

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

"Bad debt" means revenue amounts deemed uncollectable due to a patient's unwillingness to pay as determined after collection efforts based upon sound credit and collection policies.

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

"Charity care" means health care services delivered to a patient for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person. "Charity care" does not include care provided for a fee subsequently deemed uncollectable as bad debt. [ For a nursing home as defined in § 32.1-123, "charity care" means care at a reduced rate to indigent persons. ]

"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 Department of Behavioral Health and Developmental Services, whether operated for profit or nonprofit and whether privately owned or privately operated or owned or operated by a local governmental unit, (i) by or in which health services are furnished, conducted, operated or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated persons who are injured or physically sick or have mental illness, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled or crippled or (ii) 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. Intermediate care facilities, except those intermediate care facilities established for individuals with intellectual disability (ICF/MR) that have no more than 12 beds and are in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services.

5. Extended care facilities.

6. Mental hospitals.

7. Facilities for individuals with intellectual disability.

8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of individuals with substance abuse.

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, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or

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59 such other specialty services as may be designated by the Board by regulation.

60 10. Rehabilitation hospitals.

61 11. Any facility licensed as a hospital.

62 The term "medical care facility" does not include any facility of (i) the Department of Behavioral  
63 Health and Developmental Services; (ii) any nonhospital substance abuse residential treatment program  
64 operated by or contracted primarily for the use of a community services board under the Department of  
65 Behavioral Health and Developmental Services' Comprehensive State Plan; (iii) an intermediate care  
66 facility for individuals with intellectual disability (ICF/MR) that has no more than 12 beds and is in an  
67 area identified as in need of residential services for individuals with intellectual disability in any plan of  
68 the Department of Behavioral Health and Developmental Services; (iv) a physician's office, except that  
69 portion of a physician's office described in subdivision 9 of the definition of "medical care facility"; (v)  
70 the Wilson Workforce and Rehabilitation Center of the Department for Aging and Rehabilitative  
71 Services; (vi) the Department of Corrections; or (vii) the Department of Veterans Services. "Medical  
72 care facility" shall also not include that portion of a physician's office dedicated to providing nuclear  
73 cardiac imaging.

74 "Project" means:

75 1. Establishment of a medical care facility;

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

77 3. Relocation of beds from one existing facility to another, provided that "project" does not include  
78 the relocation of up to 10 beds or 10 percent of the beds, whichever is less, (i) from one existing  
79 facility to another existing facility at the same site in any two-year period, or (ii) in any three-year  
80 period, from one existing nursing home facility to any other existing nursing home facility owned or  
81 controlled by the same person that is located either within the same planning district, or within another  
82 planning district out of which, during or prior to that three-year period, at least 10 times that number of  
83 beds have been authorized by statute to be relocated from one or more facilities located in that other  
84 planning district and at least half of those beds have not been replaced, provided further that, however, a  
85 hospital shall not be required to obtain a certificate for the use of 10 percent of its beds as nursing  
86 home beds as provided in § 32.1-132;

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

90 5. Introduction into an existing medical care facility of any new cardiac catheterization, computed  
91 tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI),  
92 magnetic source imaging (MSI), medical rehabilitation, neonatal special care, obstetrical, open heart  
93 surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service,  
94 radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging, except for  
95 the purpose of nuclear cardiac imaging, substance abuse treatment, or such other specialty clinical  
96 services as may be designated by the Board by regulation, which the facility has never provided or has  
97 not provided in the previous 12 months;

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

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

106 8. Any capital expenditure of \$15 million or more, not defined as reviewable in subdivisions 1  
107 through 7 of this definition, by or on behalf of a medical care facility other than a general hospital.  
108 Capital expenditures of \$5 million or more by a general hospital and capital expenditures between \$5  
109 and \$15 million by a medical care facility other than a general hospital shall be registered with the  
110 Commissioner pursuant to regulations developed by the Board. The amounts specified in this subdivision  
111 shall be revised effective July 1, 2008, and annually thereafter to reflect inflation using appropriate  
112 measures incorporating construction costs and medical inflation. Nothing in this subdivision shall be  
113 construed to modify or eliminate the reviewability of any project described in subdivisions 1 through 7  
114 of this definition when undertaken by or on behalf of a general hospital; or

115 9. Conversion in an existing medical care facility of psychiatric inpatient beds approved pursuant to a  
116 Request for Applications (RFA) to nonpsychiatric inpatient beds.

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

120 "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.

**§ 32.1-102.2. Regulations.**

A. The Board shall promulgate regulations ~~which~~ *that* are consistent with this article and:

1. Shall establish concise procedures for the prompt review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects. In any structured batching process established by the Board, applications, combined or separate, for computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, or nuclear imaging shall be considered in the radiation therapy batch. A single application may be filed for a combination of (i) radiation therapy, stereotactic radiotherapy and proton beam therapy, and (ii) any or all of the computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, and nuclear medicine imaging;

2. May classify projects and may eliminate one or more or all of the procedures prescribed in § 32.1-102.6 for different classifications;

3. May provide for exempting from the requirement of a certificate projects determined by the Commissioner, upon application for exemption, to be subject to the economic forces of a competitive market or to have no discernible impact on the cost or quality of health services;

4. Shall establish specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas and providing for weighted calculations of need based on the barriers to health care access in such rural areas in lieu of the determinations of need used for the particular proposed project within the relevant health systems area as a whole;

5. May establish, on or after July 1, 1999, a schedule of fees for applications for certificates to be applied to expenses for the administration and operation of the certificate of public need program. Such fees shall not be less than \$1,000 nor exceed the lesser of one percent of the proposed expenditure for the project or \$20,000. Until such time as the Board shall establish a schedule of fees, such fees shall be one percent of the proposed expenditure for the project; however, such fees shall not be less than \$1,000 or more than \$20,000; and

6. Shall establish an expedited application and review process for any certificate for projects reviewable pursuant to subdivision 8 of the definition of "project" in § 32.1-102.1. Regulations establishing the expedited application and review procedure shall include provisions for notice and opportunity for public comment on the application for a certificate, and criteria pursuant to which an application that would normally undergo the review process would instead undergo the full certificate of public need review process set forth in § 32.1-102.6.

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations. However, the Commissioner may approve a significant change in cost for an approved project that exceeds the authorized capital expenditure by more than 20 percent, provided the applicant has demonstrated that the cost increases are reasonable and necessary under all the circumstances and do not result from any material expansion of the project as approved.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of *charity* care ~~at a reduced rate to indigents~~ *indigent persons* or accept patients requiring specialized care. In addition, the Board's licensure regulations shall direct the Commissioner to condition the issuing or renewing of any license for any applicant whose certificate was approved upon such condition on whether such applicant has complied with any agreement to provide a level of *charity* care ~~at a reduced rate to indigents~~ *indigent persons* or accept patients requiring specialized care. [ ~~The Except in the case of nursing homes, the~~ ] *value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.*

**§ 32.1-102.4. Conditions of certificates; monitoring; revocation of certificates.**

A. A certificate shall be issued with a schedule for the completion of the project and a maximum capital expenditure amount for the project. The schedule may not be extended and the maximum capital expenditure may not be exceeded without the approval of the Commissioner in accordance with the regulations of the Board.

B. The Commissioner shall monitor each project for which a certificate is issued to determine its

182 progress and compliance with the schedule and with the maximum capital expenditure. The  
183 Commissioner shall also monitor all continuing care retirement communities for which a certificate is  
184 issued authorizing the establishment of a nursing home facility or an increase in the number of nursing  
185 home beds pursuant to § 32.1-102.3:2 and shall enforce compliance with the conditions for such  
186 applications which are required by § 32.1-102.3:2. Any willful violation of a provision of § 32.1-102.3:2  
187 or conditions of a certificate of public need granted under the provisions of § 32.1-102.3:2 shall be  
188 subject to a civil penalty of up to \$100 per violation per day until the date the Commissioner determines  
189 that such facility is in compliance.

190 C. A certificate may be revoked when:

191 1. Substantial and continuing progress towards completion of the project in accordance with the  
192 schedule has not been made;

193 2. The maximum capital expenditure amount set for the project is exceeded;

194 3. The applicant has willfully or recklessly misrepresented intentions or facts in obtaining a  
195 certificate; or

196 4. A continuing care retirement community applicant has failed to honor the conditions of a  
197 certificate allowing the establishment of a nursing home facility or granting an increase in the number of  
198 nursing home beds in an existing facility which was approved in accordance with the requirements of  
199 § 32.1-102.3:2.

200 D. Further, the Commissioner shall not approve an extension for a schedule for completion of any  
201 project or the exceeding of the maximum capital expenditure of any project unless such extension or  
202 excess complies with the limitations provided in the regulations promulgated by the Board pursuant to  
203 § 32.1-102.2.

204 E. Any person willfully violating the Board's regulations establishing limitations for schedules for  
205 completion of any project or limitations on the exceeding of the maximum capital expenditure of any  
206 project shall be subject to a civil penalty of up to \$100 per violation per day until the date of  
207 completion of the project.

208 F. The Commissioner may condition, pursuant to the regulations of the Board, the approval of a  
209 certificate (i) upon the agreement of the applicant to provide a level of *charity* care at a ~~reduced rate~~ to  
210 ~~indigents~~ *indigent persons* or accept patients requiring specialized care or (ii) upon the agreement of the  
211 applicant to facilitate the development and operation of primary medical care services in designated  
212 medically underserved areas of the applicant's service area. [ ~~The Except in the case of nursing homes,~~  
213 ~~the~~ ] *value of charity care provided to individuals pursuant to this subsection shall be based on the*  
214 *provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for*  
215 *reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.*

216 The certificate holder shall provide documentation to the Department demonstrating that the  
217 certificate holder has satisfied the conditions of the certificate, *including documentation of the amount of*  
218 *charity care provided to patients*. If the certificate holder is unable or fails to satisfy the conditions of a  
219 certificate, the Department may approve alternative methods to satisfy the conditions pursuant to a plan  
220 of compliance. The plan of compliance shall identify a timeframe within which the certificate holder  
221 will satisfy the conditions of the certificate, and identify how the certificate holder will satisfy the  
222 conditions of the certificate, which may include (i) (a) making direct payments to an organization  
223 authorized under a memorandum of understanding with the Department to receive contributions  
224 satisfying conditions of a certificate, (ii) (b) making direct payments to a private nonprofit foundation  
225 that funds basic insurance coverage for indigents authorized under a memorandum of understanding with  
226 the Department to receive contributions satisfying conditions of a certificate, or (iii) (c) other  
227 documented efforts or initiatives to provide primary or specialized care to underserved populations. In  
228 determining whether the certificate holder has met the conditions of the certificate pursuant to a plan of  
229 compliance, only such direct payments, efforts, or initiatives made or undertaken after issuance of the  
230 conditioned certificate shall be counted towards satisfaction of conditions.

231 Any person willfully refusing, failing, or neglecting to honor such agreement shall be subject to a  
232 civil penalty of up to \$100 per violation per day until the date of compliance.

233 G. Pursuant to regulations of the Board, the Commissioner may accept requests for and approve  
234 amendments to conditions of existing certificates related to the provision of care at reduced rates or to  
235 patients requiring specialized care or related to the development and operation of primary medical care  
236 services in designated medically underserved areas of the certificate holder's service area.

237 H. For the purposes of this section, "completion" means conclusion of construction activities  
238 necessary for the substantial performance of the contract.

239 **§ 32.1-276.5. Providers to submit data.**

240 A. Every health care provider shall submit data as required pursuant to regulations of the Board,  
241 consistent with the recommendations of the nonprofit organization in its strategic plans submitted and  
242 approved pursuant to § 32.1-276.4, and as required by this section. *Such data shall include data and*  
243 *information identifying any parent company of the health care provider and any subsidiary company of*

the health care provider. Notwithstanding the provisions of Chapter 38 (§ 2.2-3800 et seq.) of Title 2.2, it shall be lawful to provide information in compliance with the provisions of this chapter.

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

C. Every medical care facility as that term is defined in § 32.1-102.1 that furnishes, conducts, operates, or offers any reviewable service shall report data on utilization of such service to the Commissioner, who shall contract with the nonprofit organization authorized under this chapter to collect and disseminate such data. For purposes of this section, "reviewable service" shall mean inpatient beds, operating rooms, nursing home services, cardiac catheterization, computed tomographic (CT) scanning, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging, medical rehabilitation, neonatal special care, obstetrical services, open heart surgery, positron emission tomographic (PET) scanning, psychiatric services, organ and tissue transplant services, radiation therapy, stereotactic radiotherapy, proton beam therapy, nuclear medicine imaging except for the purpose of nuclear cardiac imaging, and substance abuse treatment.

*Every medical care facility for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report data on (i) the total amount of charity care, as defined in § 32.1-102.1, that the facility provides to indigent persons; (ii) the number of patients to whom charity care is provided; (iii) the specific services delivered to patients that are reported as charity care; and (iv) the portion of the total amount of charity care provided that each service represents. The value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. [ Notwithstanding the foregoing, every nursing home as defined in § 32.1-123 for which a certificate of public need with conditions imposed pursuant to § 32.1-102.4 is issued shall report data on utilization and other data in accordance with regulations of the Board. ]*

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

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

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