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HOUSE BILL NO. 1272

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions on February 8, 2000)

(Patron Prior to Substitute—Delegate Rust)

A BILL to amend and reenact §§ 32.1-102.1 through 32.1-102.12, 32.1-124, and 32.1-332 through 32.1-342 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 5 of Title 32.1 an article numbered 8, consisting of sections numbered 32.1-162.15:01 through 32.1-162.15:05, relating to regulation of health care facilities.

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1 through 32.1-102.12, 32.1-124, and 32.1-332 through 32.1-342 of the Code of Virginia are amended and reenacted, and that the Code of Virginia is amended by adding in Chapter 5 of Title 32.1 an article numbered 8, consisting of sections numbered 32.1-162.15:01 through 32.1-162.15:05 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~~ *nursing home, certified nursing facility, intermediate care facility, extended-care facility or long-term care hospital*, 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~~*long-term care* insurance programs or prepaid medical service plans *or the federal Medicare program or the Virginia Medicaid program*. 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*2*. Intermediate care facilities.

5*3*. Extended care facilities.

~~6. Mental hospitals.~~

~~7. Mental retardation facilities.~~

~~8. 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, or such other specialty services as may be designated by the Board by regulation.~~

~~10. Rehabilitation hospitals.~~

11*4*. Any facility licensed as a ~~hospital~~ *long-term care 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.

"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; *or*

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, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which 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;~~

~~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 serves as the analytical and technical resource to the Secretary of Health and Human Resources in matters requiring health analysis and planning.

§ 32.1-102.1:1. Equipment registration required.

Within thirty calendar days of becoming contractually obligated to acquire 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, any person *so contracting* shall register such purchase with the Commissioner and the appropriate health systems agency.

§ 32.1-102.2. Regulations.

A. The Board shall promulgate regulations which 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;

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~~ *long-term care* 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; and

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.

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.

~~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 care at a reduced rate to indigents 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 care at a reduced rate to indigents or accept patients requiring specialized care.~~

§ 32.1-102.3. Certificate required; criteria for determining need.

A. No person shall commence any project without first obtaining a certificate issued by the Commissioner. No certificate may be issued unless the Commissioner has determined that a public need for the project has been demonstrated. If it is determined that a public need exists for only a portion of a project, a certificate may be issued for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan; however, if the Commissioner finds, upon presentation of appropriate evidence, that the provisions of such plan are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan.

B. In determining whether a public need for a project has been demonstrated, the Commissioner shall consider:

1. The recommendation and the reasons therefor of the appropriate health systems agency.

2. The relationship of the project to the applicable health plans of the Board and the health system agency.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

5. The extent to which the project will be accessible to ~~all~~ residents of the area proposed to be served *who have been evaluated and determined to be in need of long-term care*.

6. The area, population, topography, highway facilities and availability of the *long-term care* services ~~to be provided by the project~~ in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to *long-term* care.

7. Less costly or more effective alternate *delivery* methods of reasonably meeting identified ~~health service~~ *long-term care* needs.

8. The immediate and long-term financial feasibility of the project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

10. The availability of resources for the project.

11. The organizational relationship of the project to necessary ancillary and support services.

12. ~~The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.~~

~~13.~~ The special needs and circumstances of an applicant for a certificate~~, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider,~~ if a substantial portion of the applicant's services or resources or both is *to be* provided to individuals ~~not residing in~~ *outside* the health service area in which the project is to be located.

~~14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be~~

~~provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.~~

~~15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.~~

~~16~~*13.* In the case of a construction project, the costs and benefits of the proposed construction.

~~17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.~~

~~18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.~~

~~19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.~~

~~20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.~~

§ 32.1-102.3:1. Response to Request for Proposal and application for certificate not required of certain nursing facilities or nursing homes.

~~An~~*No response to Request for Proposals or an* application for a certificate that there exists a public need for a proposed project shall ~~not~~ be required for nursing facilities or nursing homes affiliated with facilities which, on January 1, 1982, and thereafter, meet all of the following criteria:

1. A facility which is operated as a nonprofit institution.

2. A facility which is licensed jointly by the Department of Health as a nursing facility or nursing home and by the Department of Social Services as an adult care residence.

3. A facility which observes the following restrictions on admissions:

a. Admissions are only allowed pursuant to the terms of a "life care contract" guaranteeing that the full complement of services offered by the facility is available to the resident as and when needed;

b. Admissions to the adult care residence unit are restricted to individuals defined as ambulatory by the Department of Social Services;

c. Admissions to the nursing facility or nursing home unit are restricted to those individuals who are residents of the adult care residence unit.

4. A facility in which no resident receives federal or state public assistance funds.

§ 32.1-102.3:2. Certificates of public need; applications for increases in nursing home or other extended care bed supplies to be filed in response to Requests For Applications (RFAs).

A. Except for applications for continuing care retirement community nursing home bed projects filed by continuing care providers registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 which comply with the requirements established in this section, the Commissioner of Health shall only approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article for any project which would result in an increase in the number of beds in a planning district in which nursing facility, *intermediate care* or extended care services *or long-term care hospital services* are provided when such applications are filed in response to Requests For Applications (RFAs).

B. The Board of Health shall adopt regulations establishing standards for the approval and issuance of Requests for Applications by the Commissioner of Health. The standards shall include, but shall not be limited to, a requirement that determinations of need take into account any limitations on access to existing nursing home beds in the planning districts. The RFAs, which shall be published at least annually, shall be jointly developed by the Department of Health and the Department of Medical Assistance Services and based on analyses of the need, or lack thereof, for increases in the nursing home bed supply in each of the Commonwealth's planning districts in accordance with standards adopted by the Board of Health by regulation. The Commissioner shall only accept for review applications in response to such RFAs which conform with the geographic and bed need determinations of the specific RFA.

C. Sixty days prior to the Commissioner's approval and issuance of any Request For Applications, the Board of Health shall publish the proposed RFA in the Virginia Register for public comment together with an explanation of (i) the regulatory basis for the planning district bed needs set forth in the RFA and (ii) the rationale for the RFA's planning district designations. Any person objecting to the contents of the proposed RFA may notify, within fourteen days of the publication, the Board and the Commissioner of his objection and the objection's regulatory basis. The Commissioner shall prepare, and deliver by registered mail, a written response to each such objection within two weeks of the date of receiving the objection. The objector may file a rebuttal to the Commissioner's response in writing within five days of receiving the Commissioner's response. If objections are received, the Board may,

after considering the provisions of the RFA, any objections, the Commissioner's responses, and if filed, any written rebuttals of the Commissioner's responses, hold a public hearing to receive comments on the specific RFA. Prior to making a decision on the Request for Applications, the Commissioner shall consider any recommendations made by the Board.

D. Except for a continuing care retirement community applying for a certificate of public need pursuant to provisions of subsections A, B, and C above, applications for continuing care retirement community nursing home bed projects shall be accepted by the Commissioner of Health only if the following criteria are met: (i) the facility is registered with the State Corporation Commission as a continuing care provider pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, (ii) the number of new nursing home beds requested in the initial application does not exceed the lesser of twenty percent of the continuing care retirement community's total number of beds that are not nursing home beds or sixty beds, (iii) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed twenty percent of its total number of beds that are not nursing home beds, and (iv) the continuing care retirement community has established a qualified resident assistance policy.

E. The Commissioner of Health may approve an initial certificate of public need for nursing home beds in a continuing care retirement community not to exceed the lesser of sixty beds or twenty percent of the total number of beds that are not nursing home beds which authorizes an initial one-time, three-year open admission period during which the continuing care retirement community may accept direct admissions into its nursing home beds. The Commissioner of Health may approve a certificate of public need for nursing home beds in a continuing care retirement community in addition to those nursing home beds requested for the initial one-time, three-year open admission period if (i) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed twenty percent of its total number of beds that are not nursing beds, (ii) the number of licensed nursing home beds within the continuing care retirement community does not and will not exceed twenty percent of the number of occupied beds that are not nursing beds, and (iii) no open-admission period is allowed for these nursing home beds. Upon the expiration of any initial one-time, three-year open admission period, a continuing care retirement community which has obtained a certificate of public need for a nursing facility project pursuant to subsection D may admit into its nursing home beds (i) a standard contract holder who has been a bona fide resident of the non-nursing home portion of the continuing care retirement community for at least thirty days, or (ii) a person who is a standard contract holder who has lived in the non-nursing home portion of the continuing care retirement community for less than thirty days but who requires nursing home care due to change in health status since admission to the continuing care retirement community, or (iii) a person who is a family member of a standard contract holder residing in a non-nursing home portion of the continuing care retirement community.

F. Any continuing care retirement community applicant for a certificate of public need to increase the number of nursing home beds shall authorize the State Corporation Commission to disclose such information to the Commissioner as may be in the State Corporation Commission's possession concerning such continuing care retirement community in order to allow the Commissioner of Health to enforce the provisions of this section. The State Corporation Commission shall provide the Commissioner with the requested information when so authorized.

G. For the purposes of this section:

"Family member" means spouse, mother, father, son, daughter, brother, sister, aunt, uncle or cousin by blood, marriage or adoption.

"One-time, three-year open admission period" means the three years after the initial licensure of nursing home beds during which the continuing care retirement community may take admissions directly into its nursing home beds without the signing of a standard contract. The facility or a related facility on the same campus shall not be granted any open admissions period for any subsequent application or authorization for nursing home beds.

"Qualified resident assistance policy" means a procedure, consistently followed by a facility, pursuant to which the facility endeavors to avoid requiring a resident to leave the facility because of inability to pay regular charges and which complies with the requirements of the Internal Revenue Service for maintenance of status as a tax exempt charitable organization under § 501 (c) (3) of the Internal Revenue Code. This policy shall be (i) generally made known to residents through the resident contract and (ii) supported by reasonable and consistent efforts to promote the availability of funds, either through a special fund, separate foundation or access to other available funds, to assist residents who are unable to pay regular charges in whole or in part.

This policy may (i) take into account the sound financial management of the facility, including existing reserves, and the reasonable requirements of lenders and (ii) include requirements that residents seeking such assistance provide all requested financial information and abide by reasonable conditions,

including seeking to qualify for other assistance and restrictions on the transfer of assets to third parties.

A qualified resident assistance policy shall not constitute the business of insurance as defined in Chapter 1 (§ 38.2-100 et seq.) of Title 38.2.

"Standard contract" means a contract requiring the same entrance fee, terms, and conditions as contracts executed with residents of the non-nursing home portion of the facility, if the entrance fee is no less than the amount defined in § 38.2-4900.

H. This section shall not be construed to prohibit or prevent a continuing care retirement community from discharging a resident (i) for breach of nonfinancial contract provisions, (ii) if medically appropriate care can no longer be provided to the resident, or (iii) if the resident is a danger to himself or others while in the facility.

I. The provisions of subsections D, E, and H of this section shall not affect any certificate of public need issued prior to July 1, 1998; however, any certificate of public need application for additional nursing home beds shall be subject to the provisions of this act.

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

C. A certificate may be revoked when:

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

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

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

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

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

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

F. ~~The Commissioner may condition, pursuant to the regulations of the Board, the approval of a certificate (i) upon the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care or (ii) upon the agreement of the applicant to facilitate the development and operation of primary medical care services in designated medically underserved areas of the applicant's service area.~~

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

~~G.~~ For the purposes of this section, "completion" means conclusion of construction activities necessary for the substantial performance of the contract.

§ 32.1-102.5. Certificate not transferable.

No certificate issued for a project *as required by § 32.1-102.1* shall be transferable.

§ 32.1-102.6. Administrative procedures.

A. To obtain a certificate for a project, the applicant shall file a completed application for a certificate with the Department and the appropriate health systems agency. In order to verify the date of the Department's and the appropriate health systems agency's receipt of the application, the applicant shall transmit the document by certified mail or a delivery service, return receipt requested, or shall deliver the document by hand, with signed receipt to be provided.

Within ten calendar days of the date on which the document is received, the Department and the appropriate health systems agency shall determine whether the application is complete or not and the Department shall notify the applicant, if the application is not complete, of the information needed to complete the application.

At least thirty calendar days before any person is contractually obligated to acquire an existing medical care facility *as defined in § 32.1-102.1,* ~~the cost of which is $600,000 or more,~~ that person shall notify the Commissioner and the appropriate health systems agency of the intent~~, the services to be offered in the facility,~~ *and* the bed capacity in the facility ~~and the projected impact that the cost of the acquisition will have upon the charges for services to be provided~~. If ~~clinical services or~~ beds are proposed to be added as a result of the acquisition, the Commissioner may require the proposed new owner to obtain a certificate prior to the acquisition.

B. The appropriate health systems agency shall review each completed application for a certificate within sixty calendar days of the day which begins the 120-calendar-day review period. The health systems agency shall hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. The health systems agency shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where a project is proposed to be located at least nine calendar days prior to the public hearing. In no case shall a health systems agency hold more than two meetings on any application, one of which shall be the public hearing conducted by the board of the health systems agency or a subcommittee of the board. The applicant shall be given the opportunity, prior to the vote by the board of the health systems agency or a committee of the agency, if acting for the board, on its recommendation, to respond to any comments made about the project by the health systems agency staff, any information in a staff report, or comments by those voting; however, such opportunity shall not increase the sixty-calendar-day period designated herein for the health systems agency's review unless the applicant requests a specific extension in the health systems agency's review period.

The health systems agency shall submit its recommendations on each application and its reasons therefor to the Department within ten calendar days after the completion of its sixty-calendar-day review or such other period in accordance with the applicant's request for extension.

If the health systems agency has not completed its review within the specified sixty calendar days or such other period in accordance with the applicant's request for extension and submitted its recommendations on the application and the reasons therefor within ten calendar days after the completion of its review, the Department shall, on the eleventh calendar day after the expiration of the health systems agency's review period, proceed as though the health systems agency has recommended project approval without conditions or revision.

C. After commencement of any public hearing and before a decision is made there shall be no ex parte contacts concerning the subject certificate or its application between (i) any person acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need and (ii) any person in the Department who has authority to make a determination respecting the issuance or revocation of a certificate of public need, unless the Department has provided advance notice to all parties referred to in (i) of the time and place of such proposed contact.

D. The Department and the Commissioner shall commence the review of the application upon receipt of the completed application and simultaneously with the review conducted by the health systems agency.

A determination whether a public need exists for a project shall be made by the Commissioner within 120 calendar days of the receipt of a completed application.

The 120-calendar-day review period shall begin on the date upon which the application is determined to be complete within the batching process specified in subdivision A 1 of § 32.1-102.2.

If the application is not determined to be complete within forty calendar days from submission, the application shall be refiled in the next batch for like projects.

The provisions of the Administrative Process Act (§ 9-6.14:1 et seq.) shall only apply to those parts of the determination process for which timelines and specifications are not delineated in subsection E of this section. Further, the parties to the case shall include only the applicant, any person showing good cause~~, any third-party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area,~~ or the health systems agency if its recommendation was to deny the application.

E. Upon accepting an application as complete, the following procedure, in lieu of the Administrative Process Act, shall control:

1. The Department shall establish, for every application, a date between the eightieth and ninetieth calendar days within the 120-calendar-day review period for holding an informal fact-finding conference, if such conference is necessary.

2. The Department shall review every application at or before the seventy-fifth calendar day within the 120-calendar-day review period to determine whether an informal fact-finding conference is necessary.

3. Any informal fact-finding conference shall be to consider the information and issues in the record and shall not be a de novo review.

4. In any case in which an informal fact-finding conference is held, a date shall be established for the closing of the record which shall not be more than forty-five calendar days after the date for holding the informal fact-finding conference.

5. In any case in which an informal fact-finding conference is not held, the record shall be closed on the earlier of (i) the date established for holding the informal fact-finding conference or (ii) the date that the Department determines an informal fact-finding conference is not necessary.

6. If a determination whether a public need exists for a project is not made by the Commissioner within fifteen calendar days of the closing of the record, the Commissioner shall notify the Attorney General, in writing, that the application shall be deemed approved unless the determination shall be made within forty calendar days of the closing of the record. The Commissioner shall transmit copies of the Attorney General's notice to the other parties to the case and to any person petitioning for good cause standing.

7. In any case when a determination whether a public need exists for a project is not made by the Commissioner within forty calendar days after the closing of the record, the Department shall immediately refund fifty percent of the fee paid in accordance with § 32.1-102.2 A 4, the application shall be deemed to be approved, and the certificate shall be granted.

8. If a determination whether a public need exists for a project is not made by the Commissioner within fifteen calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications issued pursuant to § 32.1-102.3:2 may, prior to the application being deemed approved, institute a proceeding for mandamus against the Commissioner in any circuit court of competent jurisdiction.

9. If a writ of mandamus is issued against the Commissioner by the court, the Department shall be liable for the costs of the action together with reasonable attorney's fees as determined by the court.

10. Upon the filing of a petition for a writ of mandamus, the relevant application shall not be deemed approved, regardless of the lapse of time between the closing of the record and the final decision.

F. Deemed approvals shall be construed as the Commissioner's case decision on the application pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.) and shall be subject to judicial review on appeal as the Commissioner's case decision in accordance with such act.

Any person who has sought to participate in the Department's review of such deemed-to-be-approved application as a person showing good cause who has not received a final determination from the Commissioner concerning the good-cause petition shall be deemed to be a person showing good cause for purposes of appeal of the deemed approval of the certificate.

G. For purposes of this section, "good cause" shall mean that (i) there is significant relevant information not previously presented at and not available at the time of the public hearing, (ii) there have been significant changes in factors or circumstances relating to the application subsequent to the public hearing, or (iii) there is a substantial material mistake of fact or law in the Department staff's report on the application or in the report submitted by the health systems agency.

H. The project review procedures shall provide for separation of the project review manager functions from the hearing officer functions. No person serving in the role of project review manager shall serve as a hearing officer.

I. The applicant, and only the applicant, shall have the authority to extend any of the time periods specified in this section.

§ 32.1-102.8. Enjoining project undertaken without certificate.

On petition of the Commissioner, the Board or the Attorney General, the circuit court of the county or city where a project is under construction or is intended to be constructed, located or undertaken shall have jurisdiction to enjoin any project which is constructed, undertaken or commenced without a certificate or to enjoin the admission of patients to the project ~~or to enjoin the provision of services through the project~~.

§ 32.1-102.9. Designation of judge.

The judge of the court to which any appeal is taken as provided in § 32.1-102.6 and the judge of the court referred to in § 32.1-102.8 shall be designated by the Chief Justice of the Supreme Court from a circuit other than the circuit where the project is or will be under construction, located or undertaken *or an adjoining circuit in the case of any project that may affect the occupancy rate of facilities in an adjoining circuit*.

§ 32.1-102.10. Commencing project without certificate grounds for refusing to issue license.

Commencing any project without a certificate required by this article shall constitute grounds for

refusing to issue a license for such project *unless such project is the subject of an exception to the law.*

§ 32.1-102.11. Application of article.

A. On and after July 1, 1992, every project of an existing or proposed medical care facility, as defined in § 32.1-102.1, shall be subject to all provisions of this article unless, with respect to such project, the owner or operator of an existing medical care facility or the developer of a proposed medical care facility (i) has, by February 1, 1992, purchased or leased equipment subject to registration pursuant to former § 32.1-102.3:4, (ii) has, by February 1, 1992, initiated construction requiring a capital expenditure exceeding one million dollars, or (iii) has made or contracted to make or otherwise legally obligated to make, during the three years ending February 1, 1992, preliminary expenditures of $350,000 or more for a formal plan of construction of the specific project, including expenditures for site acquisition, designs, preliminary or working drawings, construction documents, or other items essential to the construction of the specific project.

Any project exempted pursuant to subdivisions (ii) and (iii) of this subsection shall be limited to such construction, services, and equipment as specifically identified in the formal plan of construction which shall have existed and been formally committed to by February 1, 1992. Further, the equipment to be exempted pursuant to subdivisions (ii) and (iii) shall be limited to the number of units and any types of medical equipment, in the case of medical equipment intended to provide any services included in subdivision 6 of the definition of project in § 32.1-102.1, as are specifically identified in such plan and, in the case of all other equipment, such equipment as is appropriate for the construction and services included in such plan.

None of the exemptions provided in this subsection shall be applicable to projects which required a certificate of public need pursuant to this article on January 1, 1992.

B. Any medical care facility or entity claiming to meet one of the conditions set forth in subsection A of this section shall file a completed application for an exemption from the provisions of this article with the Commissioner by August 1, 1992. Forms for such application shall be made available by the Commissioner no later than April 1, 1992. The Commissioner may deny an exemption if the application is not complete on August 1, 1992, and the medical care facility or entity has not filed a completed application within forty-five days after notice of deficiency in the filing of the completed application. After receiving a completed application, the Commissioner shall determine whether the project has met one of the criteria for an exemption and is, therefore, exempt or has not met any of the criteria for an exemption and is, therefore, subject to all provisions of this article and shall notify the medical care facility or entity of his determination within sixty days of the date of filing of the completed application. If it is determined that an exemption exists for only a portion of a project, the Commissioner may approve an exemption for that portion and any appeal may be limited to the part of the decision with which the appellant disagrees without affecting the remainder of the decision. The Commissioner's determination shall be made in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.), except that parties to the case shall include only those parties specified in § 32.1-102.6.

C. For the purposes of this section:

"Formal plan of construction" means documentary evidence indicating that the facility, the owner or operator of the facility, or the developer of a proposed facility was formally committed to the project by February 1, 1992, and describing the specific project in sufficient detail to reasonably define and confirm the scope of the project including estimated cost, intended location, any clinical health services to be involved and any types of equipment to be purchased. Such documentary evidence shall include designs, preliminary or working drawings, construction documents or other documents which have been used to explicitly define and confirm the scope of the project for the purposes of seeking architectural or construction plans or capital to the extent that such capital was committed or agreed to be provided for such project prior to February 1, 1992.

"Initiated construction" means an owner or operator of an existing facility or the developer of a proposed facility can present evidence for a specific project that (i) a construction contract has been executed; (ii) if applicable, short-term financing has been completed; (iii) if applicable, a commitment for long-term financing has been obtained; and (iv) if the project is for construction of a new facility or expansion of an existing facility, predevelopment site work and building foundations have been completed.

"Leased" means that the owner or operator of an existing medical care facility or the developer of a proposed facility has a legally binding commitment to lease the equipment pursuant to an agreement providing for fixed, periodic payments commencing no later than June 30, 1992, including a lease-purchase agreement in which the owner or operator of the facility or developer has an option to purchase the equipment for less than fair market value upon conclusion of the lease or an installment sale agreement with fixed periodic payments commencing no later than June 30, 1992.

"Purchased" means that the equipment has been acquired by the owner or operator of an existing

~~medical care facility or the developer of a proposed medical care facility, or the owner or operator of the facility or the developer can present evidence of a legal obligation to acquire the equipment in the form of an executed contract or appropriately signed order or requisition and payment has been made in full by June 30, 1992.~~

On and after July 1, 2000, this article shall be applicable only to long-term medical care facilities as defined in § 32.1-102.1.

§ 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 of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five-year schedule for analysis of all 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 § 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 § 32.1-102.6 E, and any other data determined by the Commissioner to be relevant to the efficient operation of the program;

~~5~~*4*. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates 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~~*5*. 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~~*6*. 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.

§ 32.1-124. Exemptions.

The provisions of §§ 32.1-123 through 32.1-136 shall not be applicable to: (i) a dispensary or first-aid facility maintained by any commercial or industrial plant, educational institution or convent; (ii) an institution licensed by the State Mental Health, Mental Retardation and Substance Abuse Services Board; (iii) an institution or portion thereof licensed by the State Board of Social Services; (iv) a hospital or nursing home owned or operated by an agency of the United States government; (v) an office of one or more physicians or surgeons ~~unless such office is used principally for performing surgery~~ *except as authorized by Article 8 (§ 32.1-162.15:01 et seq.) of Chapter 5 of Title 32.1*; and (vi) a hospital or nursing home, as defined in § 32.1-123, owned or operated by an agency of the Commonwealth unless such hospital or nursing home or portion thereof is certified as a nursing facility pursuant to § 32.1-137.

Article 8.

Licensing of Specialized Health Care Facilities.

§ 32.1-162.15:01. Definitions.

As used in this article:

"Board" means the Board of Health.

"Minor surgery" means surgery that the Board of Medicine determines by regulation can safely and comfortably be performed on a patient who has received local or topical anesthesia, without more than minimal pre-operative medication or minimal intra-operative tranquilization and where the likelihood of complications requiring hospitalization is remote.

"Specialized health care facility" means any specialized center or clinic 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 source imaging (MSI), medical rehabilitation, nuclear medicine imaging, positron emission tomographic (PET) scanning or radiation therapy. "Specialized health care facility" shall not include any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services or any facility licensed as a hospital.

"Special procedure" means patient care that requires entering the body with instruments in a potentially painful manner, or which requires the patient to be immobile, for a diagnostic or therapeutic procedure requiring anesthesia.

§ 32.1-162.15:02. Licenses required; renewal.

A. No person shall perform surgery, other than minor surgery, or special procedures or administer anesthesia services in a specialized health care facility without a license issued pursuant to this article.

B. The Board shall issue or renew a license to perform surgery, special procedures, and administer anesthesia services in a specialized health care facility upon application therefor on a form and accompanied by a fee as prescribed by the Board, if the Board finds that the specialized health care facility is in compliance with the provisions of this article and regulations of the Board. The Board may restrict such license to particular surgical or special procedures or types of anesthesia services.

C. Every such license shall expire on the anniversary of its issuance or renewal.

D. The activities and services of each applicant for issuance or renewal of a license shall be subject to an inspection or examination by the Board of Medicine to determine if both the health care practitioner and the specialized health care facility are in compliance with the provisions of this article, regulations of the Board, and regulations of the Board of Medicine. The Board of Medicine shall report the results of each such inspection and examination to the Board.

E. No license issued pursuant to this article may be transferred or assigned.

§ 32.1-162.15:03. Qualifications for licensure.

The Board of Medicine shall establish by regulation qualifications for licensure of specialized health care facilities and minimum standards for specialized health care facilities in which surgery, special procedures or anesthesia services are to be performed. Such qualifications may include experiential requirements, board certification or other appropriate credentials for the health care practitioners who perform such services. The regulations may incorporate or apply nationally recognized, generally accepted, quality standards developed by private accreditation entities, if such standards exist, as appropriate for the license to be issued.

§ 32.1-162.15:04. Inspections.

The Board of Medicine may cause each specialized health care facility licensed under this article to be periodically inspected at reasonable times. Notwithstanding the foregoing or any other provision of this article, any specialized health care facility that has obtained accreditation from a nationally recognized accreditation entity, such as the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care, or the Joint Commission on Accreditation of Healthcare Organizations, may be subject to inspection so long as such accreditation is maintained but only to the extent necessary to ensure the public health and safety. The Board of Medicine shall report the results of each such inspection and examination to the Board.

§ 32.1-162.15:05. Revocation or suspension of license.

A. The Board is authorized to revoke or suspend any license issued hereunder if the holder of the license fails to comply with the provisions of this article or with the regulations of the Board.

B. If a license is revoked as herein provided, the Board may issue a new license upon application therefor if, when, and after the conditions upon which such revocation was based have been corrected and after compliance with all provisions of this article and applicable regulations.

C. Whenever a license is revoked or suspended, the Board may request the Office of the Attorney General to petition the circuit court of the jurisdiction in which the office is located for an injunction to cause such licensee to cease providing services.

D. Suspension of a license shall in all cases be for an indefinite time. The suspension may be lifted and rights under the license fully or partially restored at such time as the Board determines that the rights of the licensee appear to so require and that the interests of the public will not be jeopardized by resumption of operation.

§ 32.1-332. Definitions.

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

"Board" means the Board of Medical Assistance Services.

"Charity care" means hospital care for which no payment is received and which is provided to any person whose gross annual family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

"The Fund" means the Virginia Indigent Health Care Trust Fund created by this chapter.

"Hospital" means any acute care hospital which is required to be licensed as a hospital pursuant to Chapter 5 (§ 32.1-123 et seq.) of this title.

"Other health care facility" means any specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, compute tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic source imaging (MSI), medical rehabilitation, nuclear medicine imaging, positron emission tomographic (PET) scanning or radiation therapy. "Other health care facility" shall not include any facility of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

"Panel" means the Technical Advisory Panel appointed pursuant to the provisions of this chapter.

"Pilot health care project" means any arrangement for purchasing or providing health care, including,

but not limited to, any accident and sickness insurance, health services plan, or health care plan.

"Voluntary contributions or donations" means any money voluntarily contributed or donated to the fund by hospitals, *other health care facilities* or other private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

§ 32.1-333. Creation of fund; administration.

A. There is hereby created the Virginia Indigent Health Care Trust Fund whose purpose is to receive moneys appropriated by the Commonwealth and contributions from certain hospitals and others for the purpose of distributing these moneys to certain hospitals subject to restrictions as provided in this chapter.

B. The fund shall be the responsibility of the Board and Department of Medical Assistance Services and shall be maintained and administered separately from any other program or fund of the Board and Department. However, all funds voluntarily contributed or donated to the fund for the purpose of subsidizing pilot health care projects for the uninsured, including any funds voluntarily contributed by local governments, shall be administered by the Technical Advisory Panel in accordance with Board regulations.

C. The Board may promulgate rules and regulations pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.) for the administration of the fund consistent with this chapter, including but not limited to:

1. Uniform eligibility criteria to define those medically indigent persons whose care shall qualify a hospital for reimbursement from the fund. Such criteria shall define medically indigent persons as only those individuals whose gross family income is equal to or less than 100 percent of the federal nonfarm poverty level as published for the then current year in the Code of Federal Regulations.

2. Hospital inpatient and outpatient medical services qualifying for reimbursement from the fund. Such medical services shall be limited to those categories of inpatient and outpatient hospital services covered under the Medical Assistance Program, but shall exclude any durational or newborn infant service limitations.

3. A mechanism to ensure that hospitals are compensated from the fund only for charity care as defined in this chapter.

4. Terms, conditions, and reporting requirements for hospitals *and other health care facilities* participating in the fund.

5. Terms, conditions, and reporting requirements for pilot health care projects for the uninsured.

§ 32.1-334. Fund contributions.

The fund shall be comprised of such moneys as may be appropriated by the General Assembly for the purposes of the fund and by contributions from hospitals *and other health care facilities* made in accordance with the provisions of this chapter. The fund may also receive voluntary contributions from hospitals, *other health care facilities,* and other entities, including local governments, as specified by law.

§ 32.1-335. Technical Advisory Panel.

The Board shall annually appoint a Technical Advisory Panel whose duties shall include recommending to the Board (i) policy and procedures for administration of the fund, (ii) methodology relating to creation of charity care standards, eligibility and service verification, and (iii) contribution rates and distribution of payments. The Panel shall also advise the Board on any matters relating to the governance or administration of the fund as may from time to time be appropriate and on the establishment of pilot health care projects for the uninsured. In addition to these duties, the Panel shall, in accordance with Board regulations, establish pilot health care projects for the uninsured and shall administer any money voluntarily contributed or donated to the fund by private or public sources, including local governments, for the purpose of subsidizing pilot health care projects for the uninsured.

The Panel shall consist of ~~fifteen~~ *sixteen* members as follows: the Chairman of the Board, the Director of the Department of Medical Assistance Services, the Commissioner of Health, the Commissioner of the Bureau of Insurance or his designee, the chairman of the Virginia Health Care Foundation or his designee, two additional members of the Board, one of whom shall be the representative of the hospital industry *and one of whom shall be a physician*, and two chief executive officers of hospitals as nominated by the Virginia Hospital Association.

In addition, there shall be three representatives of private enterprise who shall be executives serving in business or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the business and industry community in Virginia including, but not limited to, the Virginia Manufacturers Association, the Virginia Chamber of Commerce, the Virginia Retail Merchants Association, and the Virginia Small Business Advisory Board. There shall be two representatives from the insurance industry who shall be executives serving in insurance companies or industry organizations. Nominations for these appointments may be submitted to the Board by associations representing constituents of the insurance industry in Virginia including, but not limited to, Blue Cross/Blue Shield of Virginia, Health Insurance Association of America and the

Virginia Association of Health Maintenance Organizations. There shall be ~~one~~ *two* physician ~~member~~ *members*. Nominations for ~~this~~ ~~appointment~~*these appointments* may be submitted to the Board by associations representing medical professionals, including, but not limited to, the Medical Society of Virginia and the Old Dominion Medical Society.

§ 32.1-336. Annual charity care data submission.

No later than 120 days following the end of each of its fiscal years, each hospital *or other health care facility* shall file with the Department a statement of charity care and such other data as may be required by the Department. The Department may grant one 30-day extension of the filing date to hospitals *or other health care facilities* unable to meet the 120-day requirement. Data required for carrying out the purposes of this chapter may be supplied to the Department by the Board of Health. The Board shall prescribe a procedure for alternative data gathering in cases of extreme hardship or impossibility of compliance by a hospital *or other health care facility licensed by the Board*.

§ 32.1-337. Hospital and other health care facility contributions; calculations.

A. Hospitals shall make contributions to the fund in accordance with the following:

~~A~~*1*. A charity care standard shall be established annually as follows: For each hospital, a percentage shall be calculated of which the numerator shall be the charity care charges and the denominator shall be the gross patient revenues as reported by that hospital. This percentage shall be the charity care percent. The median of the percentages of all such hospitals shall be the standard.

~~B~~*2*. Based upon the general fund appropriation to the fund and the contribution, a disproportionate share level shall be established as a percentage above the standard not to exceed three percent above the standard.

~~C~~*3*. The cost of charity care shall be each hospital's charity care charges multiplied by each hospital's cost-to-charge ratio as determined in accordance with the Medicare cost finding principles. For those hospitals whose mean Medicare patient days are greater than two standard deviations below the Medicare statewide mean, the hospital's individual cost-to-charge ratio shall be used.

~~D~~*4*. An annual contribution shall be established which shall be equal to the total sum required to support charity care costs of hospitals between the standard and the disproportionate share level. This sum shall be equally funded by hospital contributions and general fund appropriations.

~~E~~*5*. A charity care and corporate tax credit shall be calculated, the numerator of which shall be each hospital's cost of charity care plus state corporate taxes and the denominator of which shall be each hospital's net patient revenues as defined by the Board of Medical Assistance Services.

~~F~~*6*. An annual hospital contribution rate shall be calculated, the numerator of which shall be the sum of one-half the contribution plus the sum of the product of the contributing hospitals' credits multiplied by the contributing hospitals' positive operating margins and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals. The annual hospital contribution rate shall not exceed 6.25 percent of a hospital's positive operating margin.

~~G~~*7*. For each hospital, the contribution dollar amount shall be calculated as the difference between the rate and the credit multiplied by each hospital's operating margin. In addition to the required contribution, hospitals may make voluntary contributions or donations to the fund for the purpose of subsidizing pilot health care projects for the uninsured.

B. Other health care facilities, as defined in § 32.1-332, shall make contributions to the fund as follows:

1. A health care facility contribution rate shall be calculated, the numerator of which shall be one-half of the contribution established in subsection A 4 of this section and the denominator of which shall be the sum of the positive operating margins for the contributing hospitals.

2. The annual health care facility contribution rate shall not, however, exceed 6.25 percent of the health care facility's positive operating margin.

3. The dollar amount of any health care facility's contribution shall be calculated as the annual health care facility contribution rate multiplied by the positive operating margin of the contributing health care facility.

4. Any health care facility that is owned, in whole or in part, by a contributing hospital shall not contribute separately to the fund; however, such health care facility shall be included in the reports and calculations of the contribution of the hospital that owns or operates the health care facility.

~~H~~*C*. The fund shall be established on the books of the Comptroller so as to segregate the amounts appropriated and contributed thereto and the amounts earned or accumulated therein and any amounts voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured. No portion of the fund shall be used for a purpose other than that described in this chapter. Any money remaining in the fund at the end of a biennium shall not revert to the general fund but shall remain in the fund to be used only for the purpose described in this chapter, including any money voluntarily contributed or donated for the purpose of subsidizing pilot health care projects for the uninsured, whether from private or public sources.

§ 32.1-338. Distribution of fund moneys.

A. The fund shall compensate a hospital for such hospital's charity care percent less the charity care standard as follows:

1. The payment to each hospital shall be determined as the standard subtracted from each hospital's charity care percent, multiplied by each hospital's gross patient revenues, multiplied by each hospital's cost-to-charge ratio and multiplied by a percentage not to exceed sixty percent.

2. That portion of a hospital's charity care percent which is below the disproportionate share *or such other standard of indigent health care as may be established by the Board* shall be paid from the total amount of the contribution.

3. That portion of a hospital's charity care percent which is above the disproportionate share shall be paid solely from general fund moneys as provided by the General Assembly in the appropriations act.

B. Each hospital eligible to receive a fund payment may elect to return such payment or a portion thereof to the fund to be used at the discretion of the Board, upon the recommendation of the Technical Advisory Panel, for the purpose of establishing pilot health care projects for the uninsured.

C. Money voluntarily contributed or donated to the fund by private or public sources, including local governing bodies, for the purpose of subsidizing pilot health care projects for the uninsured shall not be included in the calculations set forth in this section.

§ 32.1-339. Frequency of calculations, contributions and distributions.

Contributions to the Fund by hospitals *and other health care facilities* shall be made once annually in January ~~of each calendar year beginning in January 1991~~, using financial data for the hospitals' *or other health care facilities'* most recent fiscal years ending on or before June 30 of the preceding calendar year. Calculations for distributions shall be made under the same terms. The policy and details relating to receipt of contributions and distribution of the Fund moneys shall be prescribed by the Board.

§ 32.1-340. Annual report.

The Board and Director shall report to the Governor and the General Assembly prior to the ~~1990~~*2001* Session of the General Assembly on any statutory modifications identified by the Board which are required to carry out the purposes of this chapter effectively. In January of ~~1991~~*2002*, the Board and the Director shall report to the Governor and the General Assembly on all moneys received and distributed *from hospitals and other health care facilities* and shall make any recommendations for changes with respect to the Fund and its administration.

§ 32.1-341. Failure to comply; fraudulently obtaining participation or reimbursement; criminal penalty.

A. Any person who engages in the following activities, on behalf of himself or another, shall be guilty of a Class 1 misdemeanor in addition to any other penalties provided by law:

1. Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact in order to participate in or receive reimbursement from the Fund;

2. Knowingly and willfully failing to provide reports to the Department as required in this chapter; or

3. Knowingly and willfully failing to pay in a timely manner the contribution to the Fund by a hospital *or other health care facility* as calculated by the Department pursuant to § 32.1-337.

B. Conviction of any provider or any employee or officer of such provider of any offense under this section shall also result in forfeiture of any payments due.

§ 32.1-342. Rights and responsibilities under this chapter.

This chapter shall not be construed as (i) creating any legally enforceable right or entitlement to payment for medical services on the part of any medically indigent person or any right or entitlement to participation or payment of any particular rate by any hospital or other participant or (ii) relieving any hospital *or other health care facility* of its obligations under the Hill-Burton Act or any other ~~similar~~ federal or state law or *any condition of a previously granted certificate of public need or other* agreement to provide unreimbursed care to indigent persons.

2. That the Boards of Health and Medicine shall promulgate regulations to implement the provisions of this act to be effective within 280 days of its enactment.

3. That the provisions of this act shall become effective on July 1, 2002.