2000 ANNUAL REPORT OF

THE JOINT COMMISSION ON HEALTH CARE

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 35

COMMONWEALTH OF VIRGINIA
RICHMOND
2001

COMMONWEALTH of VIRGINIA

Joint Commission on Health Care

Senator William T. Bolling
Chairman

Patrick W. Finnerty
Executive Director

April 5, 2001

Suite 115
Old City Hall
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
Fax (804) 786-5538

TO: The Honorable James S. Gilmore, III, Governor of Virginia
and Members of the General Assembly

Pursuant to the provisions of the *Code of Virginia* (Title 9, Chapter 38, §§9-311 through 9-316) establishing the Joint Commission on Health Care and setting forth its purpose, I have the honor of submitting herewith the Annual Report for the calendar year ending December 31, 2000.

This 2000 Annual Report includes a summary of the Joint Commission's 2000 activities and legislative recommendations to the 2001 Session of the General Assembly. Copies of the legislation sponsored by the Joint Commission during the 2001 Session also are included. In addition to this annual report, separate reports were published for each study the Joint Commission conducted during the year. These reports are available from the Joint Commission staff office.

Should you have any questions regarding our 2000 Annual Report, please contact Patrick Finnerty, Executive Director, at 804-786-5445.

Sincerely,

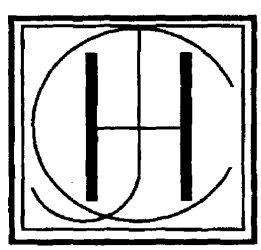
William T. Bolling
Chairman

JOINT COMMISSION ON HEALTH CARE: 2000

Chairman
The Honorable William T. Bolling
Vice Chair
The Honorable Harvey B. Morgan

The Honorable J. Randy Forbes
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Linda T. Puller
The Honorable Edward L. Schrock
The Honorable Kenneth W. Stolle
The Honorable Robert H. Brink
The Honorable L. Preston Bryant, Jr.
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable S. Chris Jones
The Honorable Kenneth R. Melvin

Secretary of Health and Human Resources
The Honorable Claude A. Allen



JOINT COMMISSION ON HEALTH CARE

Staff

Executive Director
Patrick W. Finnerty

Senior Health Policy Analysts
Joseph J. Hilbert
E. Kim Snead

Health Policy Fellow
Lisa Y. Murray, M.D.

Office Manager
Mamie V. White

Access to the Internet

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

Acknowledgements

The Joint Commission extends its sincere appreciation to the Office of the Clerk of the Senate, the Office of the Clerk of the House, the Division of Legislative Services, and the Division of Legislative Automated Systems for their assistance and support throughout 2000.

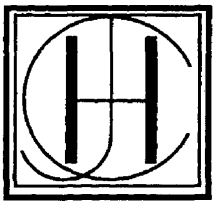


Table of Contents

I. SUMMARY OF 2000 ACTIVITIES AND RELATED 2001 GENERAL ASSEMBLY ACTIONS

STATUTORY AUTHORITY

The Joint Commission on Health Care was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians (Senate Joint Resolution 118, 1990 Session).

The Joint Commission is authorized in §9-311 et. seq. of the *Code of Virginia*. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission endeavors to ensure that the greatest number of Virginians receives quality health care.

2000 JOINT COMMISSION ACTIVITIES

During 2000, the Joint Commission held seven meetings, as well as one additional meeting in January, 2001, prior to the 2001 Session of the General Assembly. All meetings were held in the General Assembly Building in Richmond. The following paragraphs summarize the proceedings of each meeting.

May 16th Meeting

At the May 16th meeting, staff presented a final status report on the Joint Commission's 2000 legislation, and an overview of the 2000 workplan. Staff also presented a report on Virginia's Brain Injury Registry.

June 14th Meeting

During the June 14th meeting, a new Chairman and Vice Chairman of the Joint Commission were elected. Senator William T. Bolling was

elected Chairman, and Delegate Harvey B. Morgan was elected Vice Chairman.

Also during the June 14th meeting, staff presented reports on two studies: (i) patient safety and medical errors, and (ii) improving access to dental care. Lastly, Philip N. Reeves, DBA, President, Virginia Health Information, presented a report on Virginia Health Information's activities and functions.

August 2nd Meeting

The August 2nd meeting included staff presentations on two studies regarding: (i) palliative care, and (ii) long-term care insurance reporting/disclosure requirements.

E. Anne Peterson, M.D., M.P.H., State Health Commissioner, Virginia Department of Health, and Alfred W. Gross, Commissioner, State Corporation Commission's Bureau of Insurance, presented a status report on their respective agency's role in managed care oversight and regulation.

N. Stanley Fields, Medicaid Reimbursement Director of the Department of Medical Assistance Services (DMAS), presented a status report on DMAS's new methodology for nursing home reimbursement.

Dennis G. Smith, Director of DMAS, presented a status report on the Virginia Children's Medical Security Insurance Plan/Family Access to Medical Insurance Security (CMSIP/FAMIS).

August 29th Meeting

At the August 29th meeting, staff presented reports on two studies regarding: (i) confidentiality of patient medical records, and (ii) health workforce recruitment and retention issues.

Ronald C. Merrell, M.D., Stuart McGuire Professor and Chairman, Department of Surgery, Virginia Commonwealth University/Medical College of Virginia (VCU/MCV), presented a report on innovations in telemedicine applications.

Mark R. Cruise, Executive Director of the Virginia Association of Free Clinics, and John B. Cafazza, Jr., Executive Director of the Virginia Primary Care Association, presented information regarding how their organizations expended state funds that were appropriated for prescription drugs for low-income, uninsured Virginians.

September 26th Meeting

The September 26th meeting included a staff presentation on actions the Commonwealth should take to recruit, educate, and retain qualified nurses in the Commonwealth. Staff also presented summaries of three reports regarding the following issues: (i) a State Council of Higher Education for Virginia report on nurse training; (ii) a DMAS report on telemedicine issues; and (iii) a Department of Mental Health, Mental Retardation, and Substance Abuse Services proposal for implementing Joint Legislative Audit and Review Commission (JLARC) recommendations regarding mentally disabled residents in adult care residences.

Dennis G. Smith, Director of DMAS, presented a status report on the Virginia Children's Medical Security Insurance Plan/Family Access to Medical Insurance Security (CMSIP/FAMIS) and a report on the pilot indigent care pharmacy program.

State Health Commissioner E. Anne Peterson presented an update on an African-American health forum sponsored by the Virginia Department of Health.

October 24th Meeting

The October 24th meeting included a staff presentation on drug-testing policies in certain health care settings. Staff also presented summaries of two reports regarding: (i) funding of Area Health Education Center activities, and; (ii) a DMAS report on Medicaid assistance programs for low-income Medicare beneficiaries.

Ronald J. Hunt, DDS, MS, Dean, VCU/MCV Dental School, presented a proposal for establishing an externship program for dental students. Additionally, Jeffrey L. Lake, Associate Commissioner for Community Services at the Virginia Department of Health, and Karen C. Day, DDS, Director of the Division of Dental Health at the Virginia Department of Health, reported on several issues regarding the provision of dental health services by local health departments.

Philip N. Reeves, DBA, President, Virginia Health Information, presented a report on Virginia Health Information's strategic plan.

November 21st Meeting

At the November 21st meeting, staff presented a "decision matrix" that summarized all of the issues addressed by the Joint Commission

during 2000. Members made decisions on what actions to take in response to the issues contained in the "decision matrix," and requested legislation and budget amendments be drafted for introduction during the 2001 Session of the General Assembly. Staff was directed to make the draft legislation available for public comment.

January 3, 2001 Meeting

At the January 3, 2001 meeting, Dennis G. Smith presented a status report on the CMSIP/FAMIS program. Also, N. Stanley Fields presented a report on the agency's nursing home reimbursement methodology.

Staff presented the recommendations of the Long-Term Care Subcommittee. These recommendations were adopted by the full Commission. A copy of the Subcommittee report is attached at Appendix B. Staff also reviewed the public comments received on the Joint Commission's draft legislative proposals. The Commission made final decisions on proposed legislation, and adopted its package of legislative proposals and budgetary recommendations to be introduced during the 2001 Session.

SUBCOMMITTEE ACTIVITIES

In addition to the Joint Commission meetings summarized above, two subcommittees were established during 2000 to address some of the more complex and controversial studies.

Long-Term Care Subcommittee

The Long-Term Care Subcommittee, originally established in 1997, continued during 2000 and addressed a number of long-term care and aging issues. Delegate Hall chaired the Subcommittee; the other Subcommittee members were: Senators Puller and Schrock, and Delegates Brink, Hamilton, C. Jones, and Morgan.

In 2000, the Long-Term Care Subcommittee did not have any specific legislative studies to complete. In addition, the membership of the Subcommittee had changed substantially from prior years, including a new Chairman and two new JCHC members. Accordingly, the Subcommittee decided to conduct a series of meetings and public hearings across the state to learn more about various long-term care and aging issues. The primary objective of those meetings was to identify the most pressing issues that need to be studied in more depth by the Subcommittee

during 2001. The Long-Term Care Subcommittee met four times and conducted four public hearings in 2000.

The first meeting and public hearing was held at Virginia Tech on September 8, 2000. The overall theme for this meeting was to gain an overview of aging and long-term care issues. Karen A. Roberto, Ph.D., and Pamela Teaster, Ph.D., spoke of general trends in aging and long-term care and some of the studies and initiatives undertaken by the Center for Gerontology at Virginia Tech. A public hearing was held following the Subcommittee meeting.

The second meeting and public hearing was held at Christopher Newport University on October 5, 2000. The focus of the meeting was on issues related to assisted living facilities. Subcommittee members and staff conducted a site visit to Warwick Forest, a local assisted living facility. A public hearing was held following the Subcommittee meeting.

The third meeting and public hearing was held at George Mason University on November 1, 2000. The focus of the meeting was on issues related to nursing facilities and resident care. Subcommittee members and staff also conducted a site visit to Woodbine Health Care Center, a nearby nursing home. A public hearing was held following the Subcommittee meeting.

The fourth meeting and public hearing was held in the General Assembly Building in Richmond on December 7, 2000. The theme for the meeting was community-and home-based care. A public hearing was held following the Subcommittee meeting.

A more detailed summary of the Long-Term Care Subcommittee's activities as well as the Subcommittee's recommendations is attached at Appendix B.

Certificate of Public Need Subcommittee

Senate Bill 337 of the 2000 Session of the General Assembly required the Joint Commission to develop a transition plan for eliminating the Commonwealth's Certificate of Public Need (COPN) program. A Subcommittee was formed to develop the transition plan. Senator Bolling chaired the Subcommittee; other members included Senators Forbes, Lambert, Martin, Puller, and Stolle, and Delegates Brink, Bryant, DeBoer, Diamonstein, Hall, Melvin, and Morgan.

The COPN Subcommittee met five times to develop a proposed deregulation plan. The Subcommittee received briefings and information

on the following topics related to COPN: (i) an overview of previous COPN legislation; (ii) a description of the current COPN program; (iii) a survey and analysis of COPN deregulation in other states; (iv) an analysis of the indigent care burden and the uninsured population in Virginia; (v) an overview of Medicaid eligibility and provider payment levels; (vi) the impact of deregulation on the academic health centers; (vii) the impact of deregulation on the Medicaid nursing home budget; and (viii) a JLARC study of Medicaid's hospital reimbursement system. In addition, the Subcommittee held a public hearing in Richmond.

A significant component of the Subcommittee's activities involved a facilitation process in which various interested parties worked to develop a consensus deregulation plan. JCHC hired Barbara L. Hulburt, Esq. as a facilitator to assist in this process. The Medical Society of Virginia (MSV), the Virginia Hospital & Healthcare Association (VHHA), and the Virginia Health Care Association (VHCA) were identified as three key stakeholders who would participate in the facilitation. (These three organizations assisted the JCHC in paying for the facilitator's services.) Numerous other health care organizations also participated in the facilitation process. In addition, the Virginia Department of Health provided assistance throughout the process. The Department of Medical Assistance Services (DMAS), the Department of Health Professions (DHP), the State Council of Higher Education for Virginia (SCHEV), and the Office of the Attorney General also attended some meetings.

The interested parties met approximately 30 times during the Summer and Fall and made recommendations on various provisions to be included in the deregulation plan. The three key stakeholders then met several times and agreed on the final provisions of the consensus plan.

The consensus plan was presented to the COPN Subcommittee at its October 24th meeting. Public comments on the draft plan were solicited. A summary of the public comments was presented to the Subcommittee at its November 15th meeting. The Subcommittee adopted the consensus plan and recommended its approval by the full Commission. The Commission approved the plan at its November 21st meeting and directed staff to draft the necessary legislation and budget amendments to implement it.

INDIVIDUAL STUDY REPORTS PUBLISHED BY THE JOINT COMMISSION ON HEALTH CARE

During 2000, the Joint Commission conducted studies in response to fourteen legislative requests. These studies were presented in the form of "issue briefs" to the Commission during its 2000 meetings. Copies of each issue brief were distributed to persons attending the meetings at which the

study was presented to the Joint Commission, as well as to interested parties who requested copies. The issue briefs also were posted on the Joint Commission's home page on the Internet enabling persons to download the report for review and comment.

Public comments were solicited on all of the issue briefs, and a summary of the comments was presented to the Joint Commission members. Following the public comment period, all of the issue briefs were finalized and published.

In past years, all reports were printed as either a House or Senate Document. However, in 2000, the procedures for printing House and Senate documents were changed. As a result, several issue briefs prepared by the Joint Commission during 2000 were not published as legislative documents. This occurred for one of two reasons. In some cases, the issue briefs were prepared in response to a letter from the chairman of a standing committee requesting that the Joint Commission examine the subject matter of a bill that the committee failed to report, and advise the Committee of its recommendations. In other cases, the Joint Commission was directed to provide the results of the study to a particular committee or committees, as opposed to the General Assembly as a whole. For these two types of studies, no House or Senate document was published. Instead, a final report was issued and made available directly from the JCHC staff office.

Figure 1 identifies each of the Joint Commission's 2000 final reports, indicates the authority for the study, and specifies the type of final published document.

Figure 1
Studies Published by the Joint Commission on Health Care in 2000

Name of Study	Authority for Study	Published Document
Virginia's Brain Injury Registry	HJR 219/SJR 190*	House Document 43
Improving Access to Dental Care	HJR 198/HJR 296*	House Document 44
Study of Strategies to Educate, Recruit, and Retain Qualified Nurses in Virginia	HJR 288/SJR 228*	House Document 45
Palliative Care	HJR 369*	House Document 46
Patient Safety and Medical Errors	HJR 9*	House Document 47
Long-Term Care Insurance Reporting/Disclosure Requirements	HB 1511	JCHC Final Report
Review of the Confidentiality of Patient Medical Records	SB 702**	JCHC Final Report
Health Workforce Study	Item 11, Appropriations Act	JCHC Final Report
Drug-Testing Policies in Certain Health Care Settings	SB 557**	JCHC Final Report
A Plan to Eliminate the Certificate of Public Need Program	SB 337	JCHC Final Report

Notes:
* Referred by letter from Speaker of the House, S. Vance Wilkins, Jr.
** Referred by Senate Committee on Education and Health.
- Except as noted, all joint resolution and bill numbers are from the 2000 General Assembly Session. All House/Senate Document numbers are 2001 document numbers.
- Studies published as House/Senate documents are available from the Bill Room in the General Assembly Building. Studies published as a JCHC Final Report are available from the JCHC staff office.

2001 LEGISLATIVE PROPOSALS

As a result of the work completed by the Joint Commission during 2000, a package of legislative proposals (bills, resolutions, and budget amendments) was introduced during the 2001 Session of the General Assembly. The following paragraphs identify each bill and resolution and the final action taken by the General Assembly and the Governor. A copy of each bill and resolution is provided in Appendix A with the page numbers identified below.

Bills

(Unless otherwise noted, all of the following bills were approved by the General Assembly and signed by the Governor.)

SB 1084/ HB 2155 — Establishes a three-phased plan for eliminating the certificate of public need program. *Did not pass.* (Appendix A, pages 1 and 32)

SB 1085 — Extends the sunset provisions for the Joint Commission on Health Care to 2007. (Appendix A, page 14)

SB 1139/ HB 2016 — Provides that physician, nurse, dentist, physician assistant, and nurse practitioner scholarship and loan repayment monies that are awarded and eventually forfeited by recipients remain in the respective scholarship/loan repayment fund rather than reverting to the general fund. The bill also adds a loan repayment feature for RNs and LPNs. *SB 1139 was passed and signed by the Governor; HB 2016 did not pass.* (Appendix A, pages 15 and 24)

SB 1327/ HB 2319 — Establishes a pharmacist scholarship and loan repayment program. *Did not pass.* (Appendix A, pages 22 and 48)

HB 2078 — Makes the current $50 non-refundable fee that is paid for appealing managed care claims to the Bureau of Insurance's External Appeals program refundable under certain conditions. (Appendix A, page 31)

HB 2228 — Requires carriers marketing long-term care insurance policies to provide premium rate history information to applicants. This law is based on model legislation recently adopted by the National Association of Insurance Commissioners (NAIC). A second enactment clause directs the Bureau of

Insurance, in cooperation with the Joint Commission staff, to monitor the implementation of other provisions of the NAIC model act in other states. (Appendix A, page 45)

HB 2234 Includes a representative of health care employers on the Virginia Workforce Council. *This bill was not passed; however, it was incorporated into an identical bill (House Bill 2693) which was passed and approved by the Governor.* (Appendix A, page 46)

HB 2763 Requires the submission of certain outpatient surgery data by hospitals, ambulatory surgery centers and physicians. (Appendix A, page 50)

Resolutions

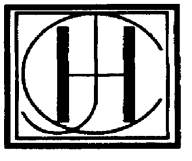
HJR 664 Requests the Virginia Partnership for Nursing to study various issues regarding RN and LPN nursing education programs in Virginia. (Appendix A, page 54)

Budget Amendment Requests

The JCHC introduced 38 budget amendment requests during the 2001 General Assembly Session. A brief description of each request is provided at Appendix C. The 2001 General Assembly did not approve any changes to the 2000-2002 biennial budget. Accordingly, none of the JCHC's budget amendment requests were funded.

APPENDIX A:

2001 Legislation



Joint Commission on Health Care
2001 Legislation

Joint Commission on Health Care
2001 Legislation

Resolutions: **Page**

014157230

SENATE BILL NO. 1084

Offered January 10, 2001

Prefiled January 10, 2001

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

Patrons—Bolling and Puller; Delegates: Brink and Diamonstein

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

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

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

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

B. Goals of the Plan shall be to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. It shall be the policy of the Commonwealth to appropriate 100 percent of the costs of the

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.

2. ~~Sanitariums.~~

~~3.~~ Nursing homes.

4*3*. Intermediate care facilities.

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

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

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

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

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

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

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

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) a physician's office, except that portion of a physician's office described

above in subdivision 9 of the definition of "medical care facility"; or (iv) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

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

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

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

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

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

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

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

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

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

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

§ 32.1-102.12. Report required.

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

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

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

~~3.~~ An analysis, *in conjunction with the Joint Commission on Health Care,* of the appropriateness

of continuing the certificate of public need program for ~~at least three~~ *various* project categories in accordance with the ~~five~~ *three*-year schedule for analysis of ~~all~~ *the* project categories;

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

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

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

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

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

Article 1.3.

Licensure of Certain Specialty Services.

§ 32.1-137.18. Definitions.

As used in this article:

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

"Board" means the Board of Health.

"Specialty Services" means any specialty service regardless of whether located in an outpatient or inpatient setting that (i) required, on July 1, 2000, a certificate of public need for the purchase of the relevant equipment, building of the relevant facility or introduction of the relevant service, and (ii) was subsequently deregulated for the purpose of the certificate of public need program in 2001 or thereafter, or (iii) such other specialty services as may be designated by the Board by regulation.

§ 32.1-137.19. Licensure required; Board regulations.

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

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

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

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

2. A list of those national accrediting organizations having standards acceptable for licensure in

Virginia, including, but not limited to, the Joint Commission on Accreditation of Health Care organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology.

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

4. Licensure application and renewal forms for specialty services.

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

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

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

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

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

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

As used in this chapter:

"Board" means the Board of Health.

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

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; ~~or~~ (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2*; or (vii) any person licensed to provide specialty services pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of this title.* In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

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

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

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

"System" means the Virginia Patient Level Data System.

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

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

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

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

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

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

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

5. That, further, upon the enactment of an appropriation act including the funding described in the fourth enactment: (i) the purchase of equipment or other capital investment necessary to plan and operate a specialty service that is to be deregulated pursuant to the second enactment shall be authorized; however, no such specialty service shall initiate operation prior to the promulgation of and compliance with the licensure requirements set forth in Article 1.3

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

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

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.
2. ~~Sanitariums.~~
~~3~~. Nursing homes.
4*3*. Intermediate care facilities.
~~5~~*4*. Extended care facilities.
~~6~~*5*. Mental hospitals.
~~7~~*6*. Mental retardation facilities.
~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
~~9~~*8*. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery~~, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation~~.
~~10~~*9*. Rehabilitation hospitals.
~~11~~*10*. Any facility licensed as a hospital.

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

"Project" means:

1. Establishment of a medical care facility;

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

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

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

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

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

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

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

~~to regulations developed by the Board~~.

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

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

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

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

10. That the provisions of the eighth enactment shall only become effective upon the inclusion in the appropriation act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) fund the second phase of improving the adequacy of Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission; (iii) fund the initial phase of the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission in 2000, if applicable; (iv) complete the phased-in funding to replace the use of clinical revenues in funding the core cost of undergraduate medical education; (v) expand phased-in Medicaid coverage for uninsured low-income parents to 66 percent of federal poverty level; (vi) provide a phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 90 percent of federal poverty level; and (vii) provide the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions.

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

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.

2. ~~Sanitariums.~~

~~3.~~ Nursing homes.

~~4~~3. Intermediate care facilities.

~~5~~4. Extended care facilities.

~~6~~5. Mental hospitals.

~~7~~6. Mental retardation facilities.

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

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

~~10~~8. Rehabilitation hospitals.

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

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

"Project" means:

1. Establishment of a medical care facility;

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

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

§ 32.1-132;

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

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

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

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

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

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

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

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

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

15. That the provisions of the thirteenth enactment shall only become effective upon the inclusion in the appropriations act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) continue the funding of increased Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission in 2000; (iii) continue funding the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission, if applicable; (iv) continue funding to replace the use of clinical revenues in supporting the core cost of undergraduate medical education; (v) complete the phased-in expansion of Medicaid reimbursement for uninsured low-income parents to 100 percent of federal poverty level; (vi) complete the phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 100 percent of federal poverty level; (vii)

Continue the provision of the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions; and (viii) fund the implementation of such recommendations as may be appropriate on graduate medical education and state support for research.

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

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

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

19. That § 32.1-102.1:1 is repealed.

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the Senate

Clerk of the House of Delegates

CHAPTER 187

An Act to amend and reenact § 9-316 of the Code of Virginia, relating to the Joint Commission on Health Care.

[S 1085]

Approved March 14, 2001

Be it enacted by the General Assembly of Virginia:

1. That § 9-316 of the Code of Virginia is amended and reenacted as follows:

§ 9-316. Sunset.

The provisions of this chapter shall expire on July 1, ~~2002~~ *2007*.

CHAPTER 188

An Act to amend and reenact §§ 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, 32.1-122.9:1, 32.1-122.10, and 54.1-3011.2 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-122.6:04, relating to conditional grants and loan repayment programs for health professionals.

[S 1139]

Approved March 14, 2001

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, 32.1-122.9:1, 32.1-122.10, and 54.1-3011.2 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-122.6:04 as follows:

§ 32.1-122.6. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual medical scholarships for students who intend to enter the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology for students in good standing at the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, and the Medical College of Hampton Roads. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships and the apportionment of the scholarships among the medical schools shall be determined annually as provided in the appropriation act; however, the Board shall reallocate annually any remaining funds from awards made pursuant to this section and § 32.1-122.5:1 among the schools participating in these scholarship programs, proportionally to their need, for additional medical scholarships for eligible students. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing boards of Virginia Commonwealth University, the University of Virginia, and the Medical College of Hampton Roads shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these medical scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing boards.

B. The Board, after consultation with the Medical College of Virginia, the University of Virginia School of Medicine, and the Medical College of Hampton Roads, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin medical practice in one of the designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete medical school or who fail to honor the obligation to engage in medical practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract;

8. Procedures for transferring unused funds upon the recommendation of the Commissioner and the approval of the Department of Planning and Budget in the event any of the medical schools has not recommended the award of its full complement of scholarships by January of each year and one or

both of the other medical schools has a demonstrated need for additional scholarships for that year; and

9. Reporting of data related to the recipients of the scholarships by the medical schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the medical course of the school nominating him for the award until his graduation or to pursue his first year of postgraduate training at the hospital or institution approved by the school nominating him for the award and upon completing a term not to exceed three years, or four years for the obstetric/gynecology specialty, as an intern or resident at an approved institution or facility intends to promptly begin and thereafter engage continuously in one of the designated specialties of medical practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of medical practice such as military service or public health service may be substituted for the obligation to practice in one of the designated specialties in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for physicians by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area in one of the designated specialties for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in medical school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice medicine in one of the designated specialties in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area in one of the designated specialties, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of medicine, whichever is later. All such funds, *including any interest thereon,* shall be ~~transmitted to the Comptroller for deposit in~~ *used only for the purposes of this section and shall not revert to* the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

H. For purposes of this section, the term "underserved area" shall include those medically

underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

§ 32.1-122.6:02. Conditional grants for certain nurse practitioner students.

A. The Board of Health shall establish annual nursing scholarships for students who intend to enter an accredited nurse practitioner or nurse midwife program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a nursing scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a nurse practitioner or nurse midwife in an underserved area of the Commonwealth within two years following completion of training;

6. Designations that students in nurse practitioner ~~specialities~~ *specialties*, including nurse midwife, receive priority scholarships;

7. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a nurse practitioner or nurse midwife for a period of years equal to the number of annual scholarships received;

8. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

9. Methods for reporting data related to the recipients of the scholarships.

C. Until such time as a fully accredited nurse midwife education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

D. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

E. Any scholarship amounts repaid by recipients pursuant to subdivision B 7, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:03. Conditional grants for certain physician assistant students.

A. The Board of Health shall establish annual physician assistant scholarships for students who intend to enter an accredited physician assistant program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a physician assistant scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations that shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for awarding the scholarship to ensure that a recipient will fulfill the practice obligations established in this section;

3. Standards to ensure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a physician assistant in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a physician assistant

for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. Prior to promulgating any regulation establishing any preferences noted in subdivision B 4, the Board shall issue written findings stating the bases for its decisions that any such preferences provided by the regulation comply with constitutional principles of equal protection.

D. Until such time as a fully accredited physician assistant education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

E. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

F. Any scholarship amounts repaid by recipients pursuant to subdivision B 6, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:04. Nurse Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a tuition loan repayment program for persons licensed as practical nurses or registered nurses who meet criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of nursing service in this Commonwealth.

B. The Board shall promulgate regulations for the implementation and administration of the Nurse Loan Repayment Program. Applications for participation in the program shall be accepted from graduates of nursing education programs that prepare them for examination for licensure as a practical nurse or registered nurse, but preference shall be given to graduates of nursing education programs located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of nursing service in the Commonwealth required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:1. Physician Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish a physician loan repayment program for graduates of accredited medical schools who have a specialty in the primary care areas of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology, and who meet other criteria as determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of medical service in this Commonwealth in a medically underserved area as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5.

B. The Board shall promulgate regulations for the implementation of the Physician Loan Repayment Program. Applications for participation in the program will be accepted from a graduate of any accredited medical school, but preference will be given to graduates of medical schools located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of medical service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.9. Conditional grants for certain dental students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual dental scholarships for students in good standing at Virginia Commonwealth University. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing board of Virginia Commonwealth University shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these dental scholarships. The Commissioner shall award the scholarships to the applicants

whose names are submitted by the governing board.

B. The Board, after consultation with the School of Dentistry of Virginia Commonwealth University, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary dental health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin dental practice in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete dental school or who fail to honor the obligation to engage in dental practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Reporting of data related to the recipients of the scholarships by the dental schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the dental course of Virginia Commonwealth University until his graduation and, upon graduation or upon completing a term not to exceed four years as an intern or resident at an approved institution or facility, to promptly begin and thereafter engage continuously in dental practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of dental practice such as military service or public health service may be substituted for the obligation to practice in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for dentists by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in dental school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of dentistry, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice dentistry in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area, the total amount of the scholarship funds received shall be reduced by the amount

of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of dentistry, whichever is later. All such funds, *including any interest thereon,* shall be ~~transmitted to the Comptroller for deposit in~~ *used only for the purposes of this section and shall not revert to* the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

H. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

§ 32.1-122.9:1. Dentist Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of dental service in this Commonwealth in an underserved area as defined in § 32.1-122.5 or a dental health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5.

B. Applications for participation in the program will be accepted from a graduate of any accredited dental school, but preference will be given to graduates of Virginia Commonwealth University's School of Dentistry.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of dental service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.10. Conditional grants for certain dental hygiene students.

A. The Board of Health shall establish annual dental hygiene scholarships for students who intend to enter an accredited dental hygiene program in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to dental hygiene care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a dental hygienist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a dental hygienist for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas

designated in accordance with the criteria established in 42 C.F.R. Part 5.

D. Any scholarship amounts repaid by recipients pursuant to subdivision B 6, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 54.1-3011.2. Nursing Scholarship and Loan Repayment Fund.

A. There is hereby established the Nursing Scholarship and Loan Repayment Fund for the purpose of financing scholarships for (i) students enrolled in or accepted for enrollment by nursing programs which will prepare such students, upon completion, for examination to be licensed by the Board as practical nurses or registered nurses and (ii) those registered nurses, licensed practical nurses, and certified nurse aides who agree to perform a period of nursing service in a Commonwealth long-term care facility pursuant to regulations promulgated by the Board of Health in cooperation with the Board.

B. The Fund shall be administered by the Board, in cooperation with the Director of the Department, and the scholarships shall be administered and awarded by the Board of Health pursuant to § 32.1-122.6:01. The Fund shall be maintained and administered separately from any other program or funds of the Board and the Department of Health Professions. No portion of the Fund shall be used for a purpose other than that described in this section and § 32.1-122.6:01. Any money remaining in the Fund at the end of a biennium, *including amounts repaid by award recipients, and any interest thereon,* shall not revert to the general fund or the funds of the Department of Health Professions, but shall remain in the Fund to be used only for the purposes of this section. In addition to any licensure fees that may be collected pursuant to § 54.1-3011.1, the Fund shall also include:

1. Any funds appropriated by the General Assembly for the purposes of the Fund; and

2. Any gifts, grants, or bequests received from any private person or organization.

Upon receiving the names of the scholarship and loan repayment program recipients from the Board of Health, the Board of Nursing shall be responsible for transmitting the funds to the appropriate institution to be credited to the account of the recipient.

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

014531230

SENATE BILL NO. 1327

Offered January 12, 2001

A BILL to amend the Code of Virginia by adding Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.10:001 and 32.1-122.10:002, relating to pharmacy student scholarship program and pharmacist loan repayment program.

Patrons—Martin, Bolling, Lambert, Puller and Stolle; Delegates: Brink, Bryant, Diamonstein, Hall, Hamilton, Jones, S.C. and Morgan

Referred to Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.10:001 and 32.1-122.10:002 as follows:

§ 32.1-122.10:001. Conditional grants for certain pharmacy students.

A. The Board of Health shall establish annual pharmacy scholarships for students who are enrolled in or who intend to enroll in an accredited school of pharmacy in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations that shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to pharmaceutical care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds, and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a pharmacist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a pharmacist for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 or health professional shortage areas designated in accordance with the criteria established in 42 C.F.R Part 5.

D. Any scholarship amounts repaid by recipients pursuant to subdivision B. 6., and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.10:002. Pharmacist Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish a pharmacist loan repayment program for graduates, of accredited pharmacy schools, who meet the criteria determined by the Board. The Board shall promulgate regulations to implement and administer the pharmacist loan repayment program. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of pharmacy service in this Commonwealth in an underserved area as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R Part 5.

B. Applications for participation in the program will be accepted from a graduate of any accredited pharmacy school in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of dental service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

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

Official Use By Clerks

Passed By The Senate		**Passed By The House of Delegates**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the Senate Clerk of the House of Delegates

014530230

HOUSE BILL NO. 2016

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact §§ 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, 32.1-122.9:1, 32.1-122.10, and 54.1-3011.2 of the Code of Virginia, and to amend the Code of Virginia by adding a section numbered 32.1-122.6:04, relating to conditional grants and loan repayment programs for health professionals.

Patrons—Hamilton, Brink and Diamonstein; Senator: Bolling

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-122.6, 32.1-122.6:02, 32.1-122.6:03, 32.1-122.6:1, 32.1-122.9, 32.1-122.9:1, 32.1-122.10, and 54.1-3011.2 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-122.6:04 as follows:

§ 32.1-122.6. Conditional grants for certain medical students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual medical scholarships for students who intend to enter the designated specialties of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology for students in good standing at the Medical College of Virginia of Virginia Commonwealth University, the University of Virginia School of Medicine, and the Medical College of Hampton Roads. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships and the apportionment of the scholarships among the medical schools shall be determined annually as provided in the appropriation act; however, the Board shall reallocate annually any remaining funds from awards made pursuant to this section and § 32.1-122.5:1 among the schools participating in these scholarship programs, proportionally to their need, for additional medical scholarships for eligible students. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing boards of Virginia Commonwealth University, the University of Virginia, and the Medical College of Hampton Roads shall submit to the Commissioner the names of those eligible applicants who are most qualified as determined by the regulations of the Board for these medical scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing boards.

B. The Board, after consultation with the Medical College of Virginia, the University of Virginia School of Medicine, and the Medical College of Hampton Roads, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin medical practice in one of the designated specialties in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete medical school or who fail to honor the obligation to engage in medical practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract;

8. Procedures for transferring unused funds upon the recommendation of the Commissioner and the

approval of the Department of Planning and Budget in the event any of the medical schools has not recommended the award of its full complement of scholarships by January of each year and one or both of the other medical schools has a demonstrated need for additional scholarships for that year; and

9. Reporting of data related to the recipients of the scholarships by the medical schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the medical course of the school nominating him for the award until his graduation or to pursue his first year of postgraduate training at the hospital or institution approved by the school nominating him for the award and upon completing a term not to exceed three years, or four years for the obstetric/gynecology specialty, as an intern or resident at an approved institution or facility intends to promptly begin and thereafter engage continuously in one of the designated specialties of medical practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of medical practice such as military service or public health service may be substituted for the obligation to practice in one of the designated specialties in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for physicians by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area in one of the designated specialties for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in medical school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of medicine, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in medical practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice medicine in one of the designated specialties in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area in one of the designated specialties, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of medicine, whichever is later. All such funds, *including any interest thereon,* shall be ~~transmitted to the Comptroller for deposit in~~ *used only for the purposes of this section and shall not revert to* the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such

collection.

H. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

§ 32.1-122.6:02. Conditional grants for certain nurse practitioner students.

A. The Board of Health shall establish annual nursing scholarships for students who intend to enter an accredited nurse practitioner or nurse midwife program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a nursing scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a nurse practitioner or nurse midwife in an underserved area of the Commonwealth within two years following completion of training;

6. Designations that students in nurse practitioner ~~specialities~~*specialties*, including nurse midwife, receive priority scholarships;

7. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a nurse practitioner or nurse midwife for a period of years equal to the number of annual scholarships received;

8. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

9. Methods for reporting data related to the recipients of the scholarships.

C. Until such time as a fully accredited nurse midwife education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

D. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

E. Any scholarship amounts repaid by recipients pursuant to subdivision B. 7., and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:03. Conditional grants for certain physician assistant students.

A. The Board of Health shall establish annual physician assistant scholarships for students who intend to enter an accredited physician assistant program in designated schools. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program through a physician assistant scholarship committee.

B. To administer the scholarship program, the Board shall promulgate regulations that shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for awarding the scholarship to ensure that a recipient will fulfill the practice obligations established in this section;

3. Standards to ensure that these scholarships increase access to primary health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, minority students and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a physician assistant in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a physician assistant for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. Prior to promulgating any regulation establishing any preferences noted in subdivision B 4, the Board shall issue written findings stating the bases for its decisions that any such preferences provided by the regulation comply with constitutional principles of equal protection.

D. Until such time as a fully accredited physician assistant education program is established at any health science center in the Commonwealth, the Board may designate that attendance at an accredited program in a nearby state is acceptable for scholarship eligibility.

E. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 and health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

F. Any scholarship amounts repaid by recipients pursuant to subdivision B. 6., and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:04. Nurse Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a tuition loan repayment program for persons licensed as practical nurses or registered nurses who meet criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of nursing service in this Commonwealth.

B. The Board shall promulgate regulations for the implementation and administration of the Nurse Loan Repayment Program. Applications for participation in the program shall be accepted from graduates of nursing education programs that prepare them for examination for licensure as a practical nurse or registered nurse, but preference shall be given to graduates of nursing education programs located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of nursing service in the Commonwealth required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.6:1. Physician Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish a physician loan repayment program for graduates of accredited medical schools who have a specialty in the primary care areas of family practice medicine, general internal medicine, pediatrics, and obstetrics/gynecology, and who meet other criteria as determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of medical service in this Commonwealth in a medically underserved area as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5.

B. The Board shall promulgate regulations for the implementation of the Physician Loan Repayment Program. Applications for participation in the program will be accepted from a graduate of any accredited medical school, but preference will be given to graduates of medical schools located in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of medical service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.9. Conditional grants for certain dental students.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish annual dental scholarships for students in good standing at Virginia Commonwealth University. No recipient shall be awarded more than five scholarships. The amount and number of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship funds.

The governing board of Virginia Commonwealth University shall submit to the Commissioner the

names of those eligible applicants who are most qualified as determined by the regulations of the Board for these dental scholarships. The Commissioner shall award the scholarships to the applicants whose names are submitted by the governing board.

B. The Board, after consultation with the School of Dentistry of Virginia Commonwealth University, shall promulgate regulations to administer this scholarship program which shall include, but not be limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarships to assure that recipients will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to primary dental health care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that bona fide residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of underserved areas are given preference over nonresidents in determining scholarship eligibility and awards;

5. Assurances that scholarship recipients will begin dental practice in an underserved area of the Commonwealth within two years following completion of their residencies;

6. Methods for reimbursement of the Commonwealth by recipients who fail to complete dental school or who fail to honor the obligation to engage in dental practice for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Reporting of data related to the recipients of the scholarships by the dental schools.

C. Prior to the award of any scholarship, the applicant shall sign a contract in which he agrees to pursue the dental course of Virginia Commonwealth University until his graduation and, upon graduation or upon completing a term not to exceed four years as an intern or resident at an approved institution or facility, to promptly begin and thereafter engage continuously in dental practice in an underserved area in Virginia for a period of years equal to the number of annual scholarships received. The contract shall specify that no form of dental practice such as military service or public health service may be substituted for the obligation to practice in an underserved area in the Commonwealth.

The contract shall provide that the applicant will not voluntarily obligate himself for more than the minimum period of military service required for dentists by the laws of the United States and that, upon completion of this minimum period of obligatory military service, the applicant will promptly begin to practice in an underserved area for the requisite number of years. The contract shall include other provisions as considered necessary by the Attorney General and the Commissioner.

The contract may be terminated by the recipient while the recipient is enrolled in dental school upon providing notice and immediate repayment of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

D. In the event the recipient fails to maintain a satisfactory scholastic standing, the recipient may, upon certification of the Commissioner, be relieved of the obligations under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds received plus interest at the prevailing bank rate for similar amounts of unsecured debt.

E. In the event the recipient dies or becomes permanently disabled so as not to be able to engage in the practice of dentistry, the recipient or his estate may, upon certification of the Commissioner, be relieved of the obligation under the contract to engage in dental practice in an underserved area upon repayment to the Commonwealth of the total amount of scholarship funds plus interest on such amount computed at eight percent per annum from the date of receipt of scholarship funds. This obligation may be waived in whole or in part by the Commissioner in his discretion upon application by the recipient or his estate to the Commissioner with proof of hardship or inability to pay.

F. Except as provided in subsections D and E, any recipient of a scholarship who fails or refuses to fulfill his obligation to practice dentistry in an underserved area for a period of years equal to the number of annual scholarships received shall reimburse the Commonwealth three times the total amount of the scholarship funds received plus interest at the prevailing bank rate for similar amounts

of unsecured debt. If the recipient has fulfilled part of his contractual obligations by serving in an underserved area, the total amount of the scholarship funds received shall be reduced by the amount of the annual scholarship multiplied by the number of years served.

G. The Commissioner shall collect all repayments required by this section and may establish a schedule of payments for reimbursement consistent with the regulations of the Board. No schedule of payments shall amortize the total amount due for a period of longer than two years following the completion of the recipient's postgraduate training or the recipient's entrance into the full-time practice of dentistry, whichever is later. All such funds, *including any interest thereon,* shall be ~~transmitted to the Comptroller for deposit in~~ *used only for the purposes of this section and shall not revert to* the general fund. If any recipient fails to make any payment when and as due, the Commissioner shall notify the Attorney General. The Attorney General shall take such action as he deems proper. In the event court action is required to collect a delinquent scholarship account, the recipient shall be responsible for the court costs and reasonable attorneys' fees incurred by the Commonwealth in such collection.

H. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

§ 32.1-122.9:1. Dentist Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board shall establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria determined by the Board. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of dental service in this Commonwealth in an underserved area as defined in § 32.1-122.5 or a dental health professional shortage area designated in accordance with the criteria established in 42 C.F.R. Part 5.

B. Applications for participation in the program will be accepted from a graduate of any accredited dental school, but preference will be given to graduates of Virginia Commonwealth University's School of Dentistry.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of dental service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.10. Conditional grants for certain dental hygiene students.

A. The Board of Health shall establish annual dental hygiene scholarships for students who intend to enter an accredited dental hygiene program in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations which shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to dental hygiene care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a dental hygienist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a dental hygienist for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. For purposes of this section, the term "underserved area" shall include those underserved areas designated by the Board pursuant to § 32.1-122.5 and dental health professional shortage areas designated in accordance with the criteria established in 42 C.F.R. Part 5.

D. Any scholarship amounts repaid by recipients pursuant to subdivision B. 6., and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 54.1-3011.2. Nursing Scholarship and Loan Repayment Fund.

A. There is hereby established the Nursing Scholarship and Loan Repayment Fund for the purpose of financing scholarships for (i) students enrolled in or accepted for enrollment by nursing programs which will prepare such students, upon completion, for examination to be licensed by the Board as practical nurses or registered nurses and (ii) those registered nurses, licensed practical nurses, and certified nurse aides who agree to perform a period of nursing service in a Commonwealth long-term care facility pursuant to regulations promulgated by the Board of Health in cooperation with the Board.

B. The Fund shall be administered by the Board, in cooperation with the Director of the Department, and the scholarships shall be administered and awarded by the Board of Health pursuant to § 32.1-122.6:01. The Fund shall be maintained and administered separately from any other program or funds of the Board and the Department of Health Professions. No portion of the Fund shall be used for a purpose other than that described in this section and § 32.1-122.6:01. Any money remaining in the Fund at the end of a biennium, *including amounts repaid by award recipients, and any interest thereon,* shall not revert to the general fund or the funds of the Department of Health Professions, but shall remain in the Fund to be used only for the purposes of this section. In addition to any licensure fees that may be collected pursuant to § 54.1-3011.1, the Fund shall also include:

1. Any funds appropriated by the General Assembly for the purposes of the Fund; and

2. Any gifts, grants, or bequests received from any private person or organization.

Upon receiving the names of the scholarship and loan repayment program recipients from the Board of Health, the Board of Nursing shall be responsible for transmitting the funds to the appropriate institution to be credited to the account of the recipient.

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

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
_____		_____	
Clerk of the House of Delegates		Clerk of the Senate	

CHAPTER 110

An Act to amend and reenact § 38.2-5901 of the Code of Virginia, relating to managed care health insurance plans; external review of utilization review decisions.

[H 2078]

Approved March 13, 2001

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-5901 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-5901. Review by the Bureau of Insurance.

A. A covered person or a treating health care provider, with the consent of the covered person, may appeal to the Bureau of Insurance for review of any final adverse decision in accordance with regulations promulgated by the Commission concerning a health service for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed, determined in accordance with regulations adopted by the Commission. The appeal shall be filed within thirty days of the final adverse decision, shall be in writing on forms prescribed by the Bureau of Insurance, shall include a general release executed by the covered person for all medical records pertinent to the appeal, and shall be accompanied by a fifty-dollar ~~nonrefundable~~ filing fee. The fee shall be collected by the Bureau of Insurance and paid directly into the state treasury and credited to the fund for the maintenance of the Bureau of Insurance as provided in subsection B of § 38.2-400. The Bureau of Insurance may, for good cause shown, waive *or refund* the filing fee upon a finding that payment of the filing fee will cause undue financial hardship for the covered person *or if the appeal is not accepted for review*. The Bureau of Insurance shall provide a copy of the written appeal to the utilization review entity which made the final adverse decision.

B. The Bureau of Insurance or its designee shall conduct a preliminary review of the appeal to determine (i) whether the applicant is a covered person or a treating health care provider acting with the consent of the covered person, (ii) whether the benefit or service that is the subject of the application reasonably appears to be a covered service for which the actual cost to the covered person would exceed $300 if the final adverse decision is not reversed, (iii) whether all complaint and appeal procedures available under Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 have been exhausted, and (iv) whether the application is otherwise complete and filed in compliance with this section. Such preliminary review shall be conducted within ten working days of receipt of all information and documentation necessary to conduct a preliminary review. The Bureau of Insurance shall not accept for review any application which fails to meet the criteria set forth in this subsection. Within five working days of completion of the preliminary review, the Bureau of Insurance or its designee shall notify the applicant and the utilization review entity in writing whether the appeal has been accepted for review, and if not accepted, the reasons therefor.

C. The covered person, the treating health care provider, and the utilization review entity shall provide copies of the medical records relevant to the final adverse decision to the Bureau of Insurance within twenty working days after the Bureau of Insurance has mailed written notice of its acceptance of the appeal. Failure to comply with such request within twenty working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision, in the discretion of the Commissioner of Insurance. The confidentiality of such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth. The Bureau of Insurance or its designee may, if deemed necessary, request additional medical records from the covered person, any treating health care provider or the utilization review entity. Failure to comply with such request within twenty working days from the date of such request may result in dismissal of the appeal or reversal of the final adverse decision in the discretion of the Commissioner of Insurance.

D. The Commissioner of Insurance, upon good cause shown, may provide an extension of time for the covered person, the treating health care provider, the utilization review entity and the Bureau of Insurance to meet the established time requirements set forth in this section.

014119230

HOUSE BILL NO. 2155

Offered January 10, 2001

Prefiled January 10, 2001

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

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

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

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

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

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

B. Goals of the Plan shall be to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. It shall be the policy of the Commonwealth to appropriate 100 percent of the costs of the

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.

~~2. Sanitariums.~~

~~3.~~ Nursing homes.

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

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

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

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

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

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

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

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

The term "medical care facility" shall not include any facility of (i) the Department of Mental Health, Mental Retardation and Substance Abuse Services; or (ii) any nonhospital substance abuse residential treatment program operated by or contracted primarily for the use of a community services board under the Department of Mental Health, Mental Retardation and Substance Abuse Services' Comprehensive Plan; or (iii) a physician's office, except that portion of a physician's office described

above in subdivision 9 of the definition of "medical care facility"; or (iv) the Woodrow Wilson Rehabilitation Center of the Department of Rehabilitative Services. ~~"Medical care facility" shall also not include that portion of a physician's office dedicated to providing nuclear cardiac imaging.~~

"Project" means:

1. Establishment of a medical care facility;

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

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

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

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

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

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

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

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

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

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

§ 32.1-102.12. Report required.

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

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

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

~~3.~~ An analysis, *in conjunction with the Joint Commission on Health Care,* of the appropriateness

of continuing the certificate of public need program for ~~at least three~~ *various* project categories in accordance with the ~~five~~ *three*-year schedule for analysis of ~~all~~ *the* project categories;

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

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

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

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

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

Article 1.3.

Licensure of Certain Specialty Services.

§ 32.1-137.18. Definitions.

As used in this article:

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

"Board" means the Board of Health.

"Specialty Services" means any specialty service regardless of whether located in an outpatient or inpatient setting that (i) required, on July 1, 2000, a certificate of public need for the purchase of the relevant equipment, building of the relevant facility or introduction of the relevant service, and (ii) was subsequently deregulated for the purpose of the certificate of public need program in 2001 or thereafter, or (iii) such other specialty services as may be designated by the Board by regulation.

§ 32.1-137.19. Licensure required; Board regulations.

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

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

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

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

2. A list of those national accrediting organizations having standards acceptable for licensure in

Virginia, including, but not limited to, the Joint Commission on Accreditation of Health Care organizations, the Accreditation Association of Ambulatory Health Care, Inc., the American Association for Accreditation of Ambulatory Surgery Facilities, Inc., and the American College of Radiology.

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

4. Licensure application and renewal forms for specialty services.

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

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

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

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

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

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

As used in this chapter:

"Board" means the Board of Health.

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

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; ~~or~~ (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2; *or (vii) any person licensed to provide specialty services pursuant to Article 1.3 (§ 32.1-137.18 et seq.) of Chapter 5 of this title.* In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

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

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

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

"System" means the Virginia Patient Level Data System.

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

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

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

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

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

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

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

5. That, further, upon the enactment of an appropriation act including the funding described in the fourth enactment: (i) the purchase of equipment or other capital investment necessary to plan and operate a specialty service that is to be deregulated pursuant to the second enactment shall be authorized; however, no such specialty service shall initiate operation prior to the promulgation of and compliance with the licensure requirements set forth in Article 1.3

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

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

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.
2. ~~Sanitariums.~~
~~3~~. Nursing homes.
~~4~~*3*. Intermediate care facilities.
~~5~~*4*. Extended care facilities.
~~6~~*5*. Mental hospitals.
~~7~~*6*. Mental retardation facilities.
~~8~~*7*. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
~~9~~*8*. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery~~, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation~~.
~~10~~*9*. Rehabilitation hospitals.
~~11~~*10*. Any facility licensed as a hospital.

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

"Project" means:

1. Establishment of a medical care facility;
2. An increase in the total number of beds or operating rooms in an existing medical care facility;
3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;
4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;
5. Introduction into an existing medical care facility of any new ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ medical rehabilitation, neonatal special care, obstetrical *service*, open heart surgery, ~~positron emission tomographic (PET) scanning,~~ psychiatric *service*, organ or tissue transplant service, ~~radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging,~~ *or* substance abuse treatment~~, or such other specialty clinical services as may be designated by the Board by regulation, which~~*that* the facility has never provided or has not provided in the previous twelve months;
6. Conversion of beds in an existing medical care facility to medical rehabilitation beds or psychiatric beds; *or*
7. The addition by an existing medical care facility of any medical equipment for the provision of ~~cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI),~~ open heart surgery~~, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation~~. Replacement of existing equipment shall not require a certificate of public need~~, or~~
~~8. Any capital expenditure of five million dollars or more, not defined as reviewable in subdivisions 1 through 7 of this definition, by or in behalf of a medical care facility. However, capital expenditures between one and five million dollars shall be registered with the Commissioner pursuant~~

~~to regulations developed by the Board~~.

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

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

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

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

10. That the provisions of the eighth enactment shall only become effective upon the inclusion in the appropriation act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) fund the second phase of improving the adequacy of Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission; (iii) fund the initial phase of the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission in 2000, if applicable; (iv) complete the phased-in funding to replace the use of clinical revenues in funding the core cost of undergraduate medical education; (v) expand phased-in Medicaid coverage for uninsured low-income parents to 66 percent of federal poverty level; (vi) provide a phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 90 percent of federal poverty level; and (vii) provide the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions.

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

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

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

§ 32.1-102.1. Definitions.

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

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

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

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

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

1. General hospitals.

2. ~~Sanitariums.~~

~~3.~~ Nursing homes.

~~4~~3. Intermediate care facilities.

~~5~~4. Extended care facilities.

~~6~~5. Mental hospitals.

~~7~~6. Mental retardation facilities.

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

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

~~10~~8. Rehabilitation hospitals.

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

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

"Project" means:

1. Establishment of a medical care facility;

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

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

§ 32.1-132;

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

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

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

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

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

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

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

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

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

15. That the provisions of the thirteenth enactment shall only become effective upon the inclusion in the appropriations act, as it shall become effective, of appropriate funding and specific and clear language denoting that such allocated funds are sufficient, as set forth in the Joint Commission on Health Care's Plan pursuant to § 32.1-102.13, to: (i) cover fully the costs of indigent care at the state-supported academic health centers, i.e., the Virginia Commonwealth University Health System Authority and the University of Virginia Medical Center, and to fund at least fifty percent of the costs of indigent care at the Eastern Virginia Medical School; (ii) continue the funding of increased Medicaid hospital reimbursement as recommended by the Joint Legislative Audit and Review Commission in 2000; (iii) continue funding the Medicaid physician payment systems in accordance with the recommendations of the Joint Legislative Audit and Review Commission, if applicable; (iv) continue funding to replace the use of clinical revenues in supporting the core cost of undergraduate medical education; (v) complete the phased-in expansion of Medicaid reimbursement for uninsured low-income parents to 100 percent of federal poverty level; (vi) complete the phased-in increase in the Medicaid income eligibility threshold for the aged and disabled to 100 percent of federal poverty level; (vii)

Continue the provision of the state match necessary for the implementation of a revised Indigent Health Care Trust Fund or any new indigent care program to incorporate providers of newly deregulated services and maintenance of the current state trust fund contributions; and (viii) fund the implementation of such recommendations as may be appropriate on graduate medical education and state support for research.

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

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

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

19. That § 32.1-102.1:1 is repealed.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

CHAPTER 114

An Act to amend and reenact § 38.2-5202 of the Code of Virginia, relating to long-term care insurance; disclosure of rating practices.

[H 2228]

Approved March 13, 2001

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-5202 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-5202. Promulgation of regulations; standards for policy provisions.

A. The Commission may adopt regulations to establish specific standards for policy provisions of long-term care insurance policies. These standards shall be in addition to and in accordance with applicable laws of this Commonwealth. The standards shall address terms of renewability, nonforfeiture provisions if applicable, initial and subsequent conditions of eligibility, continuation or conversion, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, ~~and~~ definitions of terms, *and disclosure of rating practices to consumers* and may address any other standards considered appropriate by the Commission.

B. The Commission shall promulgate such regulations regarding long-term care insurance policies and certificates as it deems appropriate.

C. Regulations issued by the Commission shall:

1. Recognize the unique, developing and experimental nature of long-term care insurance;

2. Recognize the appropriate distinctions necessary between group and individual long-term care insurance policies;

3. Recognize the unique needs of both those individuals who have reached retirement age and those preretirement individuals interested in purchasing long-term care insurance products; and

4. Recognize the appropriate distinctions necessary between long-term care insurance and accident and sickness insurance policies, prepaid health plans, and other health service plans.

2. That the Joint Commission on Health Care and the Bureau of Insurance of the State Corporation Commission shall (i) monitor the implementation of the revisions to the Long-Term Care Insurance Model Regulation of the National Association of Insurance Commissioners, dealing with Initial Filing Requirements and Premium Rate Schedule Increases, (ii) document the experience of other states that have implemented the revised regulation, and (iii) make recommendations to whether Virginia should adopt the revised regulation. The Joint Commission and the Bureau of Insurance shall report to the House Committee on Corporations, Insurance and Banking and the Senate Committee on Commerce and Labor on the progress of their study in an interim report to the 2002 Session of the General Assembly and in a final report to the 2003 Session of the General Assembly.

014533230

HOUSE BILL NO. 2234

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend and reenact § 9-329.1 of the Code of Virginia, relating to the Virginia Workforce Council; membership.

Patrons—Diamonstein, Brink, DeBoer, Deeds, Jones, J.C., Melvin and Robinson; Senator: Bolling

Referred to Committee on General Laws

Be it enacted by the General Assembly of Virginia:

1. That § 9-329.1 of the Code of Virginia is amended and reenacted as follows:

§ 9-329.1. Virginia Workforce Council established; membership; terms; chairman and vice-chairman; compensation; staff; Virginia Workforce Development Program established.

A. The Virginia Workforce Council (the Council) is hereby established to assist the Governor in meeting workforce training needs in the Commonwealth.

B. The Secretary of Commerce and Trade and the Council shall assist the Governor in complying with the provisions of the federal Workforce Investment Act (P.L. 105-220), hereinafter referred to as "the WIA," including the creation of Virginia's Workforce Development Program.

C. The Council shall be composed of the following ~~forty-three~~ *forty-four* members: the Governor; the Secretaries of Commerce and Trade, Education, Health and Human Resources, and Technology; the Director of the Department of Business Assistance; the Chancellor of the Virginia Community College System; the Director of the State Council of Higher Education; the President of the Center for Innovative Technology; the Executive Director of the Virginia Economic Development Partnership; the Director of the Governor's Employment and Training Department; the Commissioner of the Virginia Employment Commission; the president of the Virginia AFL-CIO; and one other labor representative, appointed by the Governor.

The Governor shall also appoint ~~twenty-two~~ *twenty-three* members representing the business community, to include the presidents of the Virginia Chamber of Commerce and the Virginia Manufacturer's Association; one representative of private nonprofit institutions; one representative of proprietary schools; *one representative of health care employers;* and the remaining eighteen members who are business owners, chief executive officers, chief operating officers, or other business executives or employers with optimum policy-making or hiring authority and who shall represent diverse regions of the state, to include urban, suburban, and rural areas; and members of the local workforce investment boards, representing businesses with employment opportunities that reflect the employment opportunities of the state, and who are appointed from among individuals nominated by state business organizations and business trade associations.

The Governor shall also appoint one mayor, one chairperson of a county board of supervisors, and one representative of a community-based organization delivering workforce activities.

The Council shall also include two members of the House of Delegates to be appointed by the Speaker of the House and two members of the Senate to be appointed by the Senate Committee on Privileges and Elections.

Initially, of the twenty-two members who are serving as representatives of business and industry, other than the presidents of the Virginia Chamber of Commerce and the Virginia Manufacturer's Association, eight shall serve four-year terms; six shall serve three-year terms; and six shall serve two-year terms. Thereafter, all appointments shall be for four-year terms. Appointments to fill vacancies, other than by expiration of a term, shall be for the unexpired terms. No appointed member shall be eligible to serve for more than two successive four-year terms, but after the expiration of the remainder of a term to which a member was appointed to fill a vacancy, two additional four-year terms may be served by such member if appointed. Legislative members shall serve terms coincident with their terms of office.

D. The Governor shall select a chairman and vice-chairman from among the twenty-two business representatives appointed in accordance with subsection C.

E. Appointed members of the Council shall not be compensated; however, they shall be

reimbursed for reasonable and necessary expenses incurred in the performance of their duties on behalf of the Council.

F. The Council shall assist the Governor in the following areas with respect to workforce development: development of the WIA State Plan; development and continuous improvement of a statewide system of activities that are funded under the WIA or carried out at a one-stop delivery system; development of linkages to ensure coordination and nonduplication among programs and activities; review of local plans; commenting at least once annually on the measures taken pursuant to §§ 121(a)(1)(D)(i) and 122(c)(16) and (c)(21) of the Carl D. Perkins Vocational and Technical Education Act of 1998 (20 U.S.C. § 2301 et seq.); designation of local areas; development of allocation formulas; development and continuous improvement of comprehensive state performance measures; preparation of the annual report to the U.S. Secretary of Labor; development of a statewide employment statistics system; and development of incentive grant applications.

The Council shall share information regarding its meetings and activities with the public.

G. Each local workforce investment board shall develop and submit a local plan to the Governor; designate or certify one-stop operators; identify eligible providers of youth activities; identify eligible providers of intensive services if unavailable at one-stop; develop a budget; conduct local program oversight in partnership with its local chief elected official; negotiate local performance measures; assist in developing statewide employment statistics; coordinate workforce investment activities with economic development strategies and develop linkages; develop and enter into memoranda of understanding with one-stop partners; and promote participation by the private sector.

Each local workforce investment board shall share information regarding its meetings and activities with the public.

H. Each chief local elected official shall consult with the Governor regarding designation of local workforce investment areas; appoint members to the local board in accordance with state criteria; serve as the local grant recipient unless another entity is designated in the local plan; negotiate local performance measures with the Governor; and collaborate with the local workforce investment board on local plans and program oversight.

I. The Virginia Secretary of Commerce and Trade, and at his direction, the Virginia Employment Commission, shall be responsible for the coordination of the Virginia Workforce Development Program and the implementation of the WIA.

J. The Virginia Employment Commission and the Virginia Community College System shall serve as staff to the Council as directed by the Secretary of Commerce and Trade. The Virginia Employment Commission shall act as fiscal agent for the Council and the WIA.

K. Regional workforce training centers shall be established at institutions within the Virginia Community College System in the Peninsula, Southside, Central Virginia, and Western Tidewater regions to assist the Council in (i) coordinating specific high-skill training, (ii) developing industry standards and related curricula, and (iii) providing skills assessments.

The Virginia Community College System shall evaluate other regional workforce center locations and recommend to the Council their establishment as such needs are identified. The Virginia Community College System shall support regional workforce training centers created by the Regional Competitiveness Act (§ 15.2-1306 et seq.) in which community colleges participate.

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

Clerk of the House of Delegates

Clerk of the Senate

014532230

HOUSE BILL NO. 2319

Offered January 10, 2001

Prefiled January 10, 2001

A BILL to amend the Code of Virginia by adding in Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.10:001 and 32.1-122.10:002, relating to pharmacy student scholarship program and pharmacist loan repayment program.

Patrons—Jones, S.C., Brink, Diamonstein and Morgan; Senator: Bolling

Referred to Committee on Health, Welfare and Institutions

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Article 6 of Chapter 4 of Title 32.1 sections numbered 32.1-122.10:001 and 32.1-122.10:002 as follows:

§ 32.1-122.10:001. Conditional grants for certain pharmacy students.

A. The Board of Health shall establish annual pharmacy scholarships for students who are enrolled in or who intend to enroll in an accredited school of pharmacy in the Commonwealth. The amounts and numbers of such scholarships shall be determined annually as provided in the appropriation act. The Commissioner shall act as fiscal agent for the Board in administration of the scholarship program.

B. To administer the scholarship program, the Board shall promulgate regulations that shall include, but are not limited to:

1. Qualifications of applicants;

2. Criteria for award of the scholarship to assure that a recipient will fulfill the practice obligations established in this section;

3. Standards to assure that these scholarships increase access to pharmaceutical care for individuals who are indigent or who are recipients of public assistance;

4. Assurances that residents of Virginia, as determined by § 23-7.4, students of economically disadvantaged backgrounds, and residents of medically underserved areas are given preference in determining scholarship eligibility and awards;

5. Assurances that a scholarship recipient will practice as a pharmacist in an underserved area of the Commonwealth within two years following completion of training;

6. Methods for reimbursement to the Commonwealth by a recipient who fails to complete the educational program or who fails to honor the obligation to engage in practice as a pharmacist for a period of years equal to the number of annual scholarships received;

7. Procedures for reimbursing any recipient who has repaid the Commonwealth for part or all of any scholarship and who later fulfills the terms of his contract; and

8. Methods for reporting data related to the recipients of the scholarships.

C. For purposes of this section, the term "underserved area" shall include those medically underserved areas designated by the Board pursuant to § 32.1-122.5 or health professional shortage areas designated in accordance with the criteria established in 42 C.F.R Part 5.

D. Any scholarship amounts repaid by recipients pursuant to subdivision B. 6., and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

§ 32.1-122.10:002. Pharmacist Loan Repayment Program.

A. With such funds as are appropriated for this purpose, the Board of Health shall establish a pharmacist loan repayment program for graduates, of accredited pharmacy schools, who meet the criteria determined by the Board. The Board shall promulgate regulations to implement and administer the pharmacist loan repayment program. The Commissioner shall act as the fiscal agent for the Board in administration of these funds. Prior to awarding any funds, the Board shall require the recipient to agree to perform a period of pharmacy service in this Commonwealth in an underserved area as defined in § 32.1-122.5 or a health professional shortage area designated in accordance with the criteria established in 42 C.F.R Part 5.

B. Applications for participation in the program will be accepted from a graduate of any accredited pharmacy school in the Commonwealth.

C. Any loan repayment amounts repaid by recipients who fail to honor the obligation to perform a period of pharmacy service in an underserved area as required by this section, and any interest thereon, shall be used only for the purposes of this section and shall not revert to the general fund.

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

Official Use By Clerks

Passed By The House of Delegates		**Passed By The Senate**	
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐

Date: _____ Date: _____

_____ _____

Clerk of the House of Delegates Clerk of the Senate

CHAPTER 341

An Act to amend and reenact §§ 32.1-276.3, 32.1-276.6, 32.1-276.8 and 32.1-276.9 of the Code of Virginia, relating to health care data reporting.

[H 2763]

Approved March 19, 2001

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-276.3, 32.1-276.6, 32.1-276.8 and 32.1-276.9 of the Code of Virginia are amended and reenacted as follows:

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

As used in this chapter:

"Board" means the Board of Health.

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

"Health care provider" means (i) a general hospital, ordinary hospital, outpatient surgical hospital, nursing home or certified nursing facility licensed or certified pursuant to Article 1 of Chapter 5 (§ 32.1-123 et seq.) of Title 32.1; (ii) a mental or psychiatric hospital licensed pursuant to Chapter 8 (§ 37.1-179 et seq.) of Title 37.1; (iii) a hospital operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (iv) a hospital operated by the University of Virginia or the Virginia Commonwealth University Health System Authority; (v) any person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1; or (vi) any person licensed to furnish health care policies or plans pursuant to Chapter 34 (§ 38.2-3400 et seq.), Chapter 42 (§ 38.2-4200), or Chapter 43 (§ 38.2-4300) of Title 38.2. In no event shall such term be construed to include continuing care retirement communities which file annual financial reports with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 or any nursing care facility of a religious body which depends upon prayer alone for healing.

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

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

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

"Outpatient surgery" means all surgical procedures performed on an outpatient basis in a general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title or in a physician's office. Outpatient surgery refers only to those surgical procedure groups on which data are collected by the nonprofit organization as a part of a pilot study.

"Physician" means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

"Physician's office" means a place (i) owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever or by a corporation, partnership, limited liability company or other entity that employs or engages physicians, and (ii) designed and equipped solely for the provision of fundamental medical care, whether diagnostic, therapeutic, rehabilitative, preventive or palliative, to ambulatory patients.

"Surgical procedure group" means at least five procedure groups, identified by the nonprofit organization designated pursuant to § 32.1-276.4 in compliance with regulations adopted by the Board, based on criteria that include, but are not limited to, the frequency with which the procedure is performed, the clinical severity or intensity, and the perception or probability of risk. The nonprofit organization shall form a technical advisory group consisting of members nominated by its Board of Directors' nominating organizations to assist in selecting surgical procedure groups to recommend to the Board for adoption.

"System" means the Virginia Patient Level Data System.

§ 32.1-276.6. (Effective until July 1, 2003) Patient level data system continued; reporting requirements.

A. The Virginia Patient Level Data System is hereby continued, hereinafter referred to as the "System." Its purpose shall be to establish and administer an integrated system for collection and analysis of data which shall be used by consumers, employers, providers, and purchasers of health care and by state government to continuously assess and improve the quality, appropriateness, and accessibility of health care in the Commonwealth and to enhance their ability to make effective health care decisions.

B. Every inpatient hospital shall submit to the Board patient level data as set forth in this subsection. *Every general hospital, ordinary hospital, outpatient surgical hospital or other facility licensed or certified pursuant to Article 1 (§ 32.1-123 et seq.) of Chapter 5 of this title and every physician performing surgical procedures in his office shall also submit to the board outpatient surgical data as set forth in this subsection.* Any such hospital, *facility or physician* may report the required data directly to the nonprofit organization cited in § 32.1-276.4. *Unless otherwise noted,* patient level data elements for hospital inpatients *and patients having outpatient surgery* shall include, *where applicable and included on standard claim forms*:

1. Hospital identifier;
2. Attending physician identifier *(inpatient only)*;
3. Operating physician identifier;
4. Payor identifier;
5. Employer identifier;
6. Patient identifier *(all submissions)*;
7. Patient sex, race *(inpatient only)*, date of birth (including century indicator), zip code, patient relationship to insured, employment status code, status at discharge, and birth weight for infants *(inpatient only)*;
8. Admission type, source *(inpatient only)*, date and hour, and diagnosis;
9. Discharge date *(inpatient only)* and status;
10. Principal and secondary diagnoses;
11. External cause of injury;
12. Co-morbid conditions existing but not treated;
13. Procedures and procedure dates;
14. Revenue center codes, units, and charges; and
15. Total charges.

C. State agencies providing coverage for outpatient services shall submit to the Board patient level data regarding paid outpatient claims. Information to be submitted shall be extracted from standard claims forms and, where available, shall include:

1. Provider identifier;
2. Patient identifier;
3. Physician identifier;
4. Dates of service and diagnostic, procedural, demographic, pharmaceutical, and financial information; and
5. Other related information.

The Board shall promulgate regulations specifying the format for submission of such outpatient data. State agencies may submit this data directly to the nonprofit organization cited in § 32.1-276.4.

§ 32.1-276.8. (Effective until July 1, 2003) Fees for processing, verification, and dissemination of data.

A. The Board shall prescribe a reasonable fee, not to exceed one dollar per discharge, for each health care provider submitting patient level data *on inpatients* pursuant to this chapter to cover the costs of the reasonable expenses in processing and verifying such data. The Board shall also prescribe a reasonable fee for each affected health care provider to cover the costs of the reasonable expenses of establishing and administering the methodology developed pursuant to § 32.1-276.7. The payment of such fees shall be at such time as the Board designates. The Board may assess a late charge on any fees paid after their due date.

In addition, the Board shall prescribe a tiered-fee structure based on the number of enrollees for each health maintenance organization to cover the costs of collecting and making available such data. Such fees shall not exceed $3,000 for each health maintenance organization required to provide information pursuant to this chapter. The payment of such fees shall also be at such time as the Board designates. The Board may also assess a late charge on any fees paid by health maintenance organizations after their due dates.

The Board shall (i) maintain records of its activities; (ii) collect and account for all fees and deposit the moneys so collected into a special fund from which the expenses attributed to this chapter shall be paid; and (iii) enforce all regulations promulgated by it pursuant to this chapter.

B. The nonprofit organization providing services pursuant to an agreement or contract as provided in § 32.1-276.4 shall be authorized to charge and collect the fees prescribed by the Board in subsection A of this section when the *patient level* data *on inpatients* are provided directly to the nonprofit organization. Such fees shall not exceed the amount authorized by the Board as provided in subsection A of this section. The nonprofit organization, at its discretion, may grant a reduction or waiver of the patient level data submission fees upon a determination by the nonprofit organization that the health care provider or health maintenance organization has submitted processed, verified data. *There shall be no fees for processing of outpatient surgical data for the first twelve months of data submission. Following that period, the nonprofit organization may charge a fee of up to one dollar for records that it determines are not processed, verified data.*

C. State agencies shall not be assessed fees for the submission of patient level data required by subsection C of § 32.1-276.6. Individual employers, insurers, and other organizations may voluntarily provide the nonprofit organization with outpatient data for processing, storage, and comparative analysis and shall be subject to fees negotiated with and charged by the nonprofit organization for services provided.

D. The nonprofit organization providing services pursuant to an agreement or contract with the Commissioner of Health shall be authorized to charge and collect reasonable fees for the dissemination of patient level data and Health Employer Data and Information Set (HEDIS) data or other approved quality of care or performance information set data; however, the Commissioner of Health, the State Corporation Commission, and the Commissioner of Mental Health, Mental Retardation and Substance Abuse Services shall be entitled to receive relevant and appropriate data from the nonprofit organization at no charge.

§ 32.1-276.9. (Effective until July 1, 2003) Confidentiality, subsequent release of data and relief from liability for reporting; penalty for wrongful disclosure; individual action for damages.

A. Patient level data collected pursuant to this chapter shall be exempt from the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.), shall be considered confidential, and shall not be disclosed other than as specifically authorized by this chapter; however, upon processing and verification by the nonprofit organization, all patient level data shall be publicly available, except patient, physician, and employer identifier elements, which may be released solely for research purposes if otherwise permitted by law and only if such identifier is encrypted and cannot be reasonably expected to reveal patient identities. No report published by the nonprofit organization, the Commissioner, or other person may present information that reasonably could be expected to reveal the identity of any patient. Publicly available information shall be designed to prevent persons from being able to gain access to combinations of patient characteristic data elements that reasonably could be expected to reveal the identity of any patient. The nonprofit organization, in its discretion, may release physician and employer identifier information. *Outpatient surgical charge data shall be made publicly available only pursuant to a review by the Joint Commission on Health Care.*

B. No person or entity, including the nonprofit organization contracting with the Commissioner,

shall be held liable in any civil action with respect to any report or disclosure of information made under this article unless such person or entity has knowledge of any falsity of the information reported or disclosed.

C. Any disclosure of information made in violation of this chapter shall be subject to a civil penalty of not more than $5,000 per violation. This provision shall be enforceable upon petition to the appropriate circuit court by the Attorney General, any attorney for the Commonwealth, or any attorney for the county, city or town in which the violation occurred. Any penalty imposed shall be payable to the Literary Fund. In addition, any person or entity who is the subject of any disclosure in violation of this article shall be entitled to initiate an action to recover actual damages, if any, or $500, whichever is greater, together with reasonable attorney's fees and court costs.

2. That the nonprofit health data organization referenced in § 32.1-276.4 shall review the impact of requiring the submission of outpatient surgical data by health care providers during a pilot study. A review of the pilot study shall be conducted in consultation with the various affected parties and shall include an assessment and evaluation of the logistics and costs borne by those submitting data and the actual or potential value, or both, of the outpatient data to the business community, consumers, public health and health policy officials, and health care providers. The nonprofit organization also shall consider the impact and benefit of federal regulations associated with the Health Insurance Portability and Accountability Act of 1996 as they relate to electronic transmission of data and privacy considerations. The nonprofit organization's review of the pilot study also shall assess the value of public release of information on charges for outpatient surgical procedures in consultation with the various affected and interested parties. The study's findings and recommendations shall be presented to the Joint Commission on Health Care prior to any public release of charge information for outpatient surgical procedures. Such review and study findings shall be submitted to the Joint Commission on Health Care as part of the nonprofit organization's strategic plan pursuant to § 32.1-276.4 or as a separate report.

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

HOUSE JOINT RESOLUTION NO. 664

Requesting the Virginia Partnership for Nursing, in cooperation with various state agencies and other nursing and health care organizations, to conduct a study of education programs for registered nurses (RN) and licensed practical nurses (LPN) in Virginia.

Agreed to by the House of Delegates, February 6, 2001
Agreed to by the Senate, February 21, 2001

WHEREAS, the Virginia Joint Commission on Health Care (JCHC) conducted a study of strategies to educate, train, recruit, and retain nurses pursuant to House Joint Resolution No. 288 (2000) and Senate Joint Resolution No. 228 (2000); and

WHEREAS, hospitals, long-term care facilities, home health providers and physician offices report having serious difficulties recruiting, hiring, and retaining qualified nurses; and

WHEREAS, the JCHC concluded that the hiring difficulties of health care employers will worsen in light of the fact that many researchers are projecting a significant shortage of nurses by 2008; and

WHEREAS, there are several factors believed to be driving the projected shortage, including: (i) expanded employment opportunities for women; (ii) increasing work pressures; (iii) decreasing nursing school enrollments and graduations; and (iv) an insufficient number of younger nurses entering the profession to replace those who will be retiring beginning in 2008; and

WHEREAS, admissions to education programs for registered nurses in Virginia have decreased 25 percent since 1993, and graduations have declined 20 percent since 1997; and

WHEREAS, admissions and graduations at Virginia's education programs for licensed practical nurses also have declined in recent years; and

WHEREAS, the Virginia Employment Commission projects 19 percent employment growth for registered nurses and 25 percent employment growth for licensed practical nurses between 1996 and 2006; and

WHEREAS, it is critical to increase the number of qualified persons enrolling in and graduating from Virginia's nursing education programs in order to avert a critical shortage of nurses in the future; and

WHEREAS, further study is needed to determine what actions must be taken to ensure that Virginia's nursing education programs not only enroll and graduate more nurses but also provide nurses with the necessary skills and training to meet the increasingly acute level of care required by patients; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Virginia Partnership for Nursing, in cooperation with the Virginia Nurses Association, the Virginia League for Nursing, the Virginia Association of Colleges of Nursing, the Virginia Council of Associate Degree Nurse Program Heads, the Virginia Health Occupations Education Association, the Assembly of Hospital Schools of Nursing in Virginia, the Virginia Organization of Nurse Executives, the Virginia Hospital and Healthcare Association, the Virginia Health Care Association, the Virginia Association of Nonprofit Homes for the Aging, the Virginia Association for Home Care, the State Council of Higher Education for Virginia, the Virginia Board of Nursing, and other appropriate entities, be requested to conduct a study of nursing education programs for registered nurses (RN) and licensed practical nurses (LPN) in Virginia.

The study shall include, but need not be limited to, an analysis of: (i) actions that are needed to increase the number of persons enrolling in and graduating from Virginia's RN and LPN nursing education programs; (ii) whether the capacity of Virginia's RN and LPN nursing education programs needs to be increased to meet future demands; (iii) actions that are needed to recruit and retain more nursing faculty; (iv) whether curriculum changes are needed to ensure that RN and LPN nursing education programs will meet future nurse workforce demands; (v) whether there needs to be a greater or lesser emphasis placed on certain types of RN degree programs; and (vi) other appropriate issues related to RN and LPN nursing education.

The Virginia Partnership for Nursing is requested to submit its findings and recommendations to the Joint Commission on Health Care by November 30, 2001, and to the Governor and the 2002 Session of the General Assembly as provided in the procedures of the Division of Legislative

Automated Systems for the processing of legislative documents.

APPENDIX B:

Long-Term Care Subcommittee Recommendations

JOINT COMMISSION ON HEALTH CARE
Report of the Long-Term Care Subcommittee
January 3, 2001

Subcommittee Objective for 2000

This year, the Long-Term Care Subcommittee did not have any specific legislative studies to complete. In addition, the membership of the Subcommittee had changed substantially from prior years, including a new Chairman and two new JCHC members. Accordingly, the Subcommittee decided to conduct a series of meetings and public hearings across the state to learn more about various long-term care and aging issues. The primary objective of those meetings was to identify the most pressing issues that need to be studied in more depth by the Subcommittee during 2001.

Meetings/Public Hearings Held on Long-Term Care

<u>September 8, 2000 at Virginia Tech</u>

- Theme: Overview of Aging and Long-Term Care Issues
- Presentations:
  - Karen A. Roberto, Ph.D. and Pamela Teaster, Ph.D. spoke of general trends in aging and long-term care and some of the studies and initiatives undertaken by their Center for Gerontology at Virginia Tech.
- Public Hearing:
  - Seven speakers addressed long-term care issues.

October 5, 2000 at Christopher Newport University

- Theme: Assisted Living Facilities
- Site Visit: Warwick Forest
- Presentations:
  - Beverley Soble (VHCA), Marcia Melton (VANHA), and William Murray (VHHA) recommended increasing the monthly Auxiliary Grant payment to $1,100, providing funds for a Statewide Survey of Older Virginians, addressing the loss of the Intensive Assisted Living Medicaid waiver, and unifying the funding and licensure oversight for assisted living facilities within the Adult Services Unit of the Department of Social Services.
  - Mayme E. BaCote, Newport News Council Member, asked that the state address the disproportionate impact that the local match for the Auxiliary Grant has on certain Virginia localities by eliminating the local match requirement.
  - Joan Latimer, Office of the State Long-Term Care Ombudsman, spoke about adding staff for the Ombudsman program to meet the ratio recommended by the Institute of Medicine of one ombudsman to 2,000 residents in long-term care facilities.
- Public Hearing:
  - Seven speakers addressed long-term care issues.

November 1, 2000 at George Mason University

- Theme: Nursing Facilities
- Site Visit: Woodbine Health Care Center
- Presentations:
  - Mary Lynne Bailey and Hobart Harvey of VHCA recommended increasing the Medicaid reimbursement to nursing facilities to the national median, addressing problems facilities face in hiring and retaining nursing staff, and continuing efforts to encourage the purchase and provision of long-term care insurance.
  - Deidra Abbott, HCFA's Center for Medicaid and State Operations, discussed how to successfully design a Medicaid waiver request.
  - Janet Clement, TLC 4 Long Term Care, recommended a number of measures to improve care within long-term care facilities including mandatory staffing ratios; enhanced regulatory, protective services, and law enforcement measures; and increased funding of less-expensive alternatives to nursing home care.
- Public Hearing:
  - Thirty-three speakers addressed long-term care issues.

December 7, 2000 in Richmond

- Theme: Community- and Home-Based Care
- Presentations:
  - Michael Walker, Virginia Association for Home Care, requested funding for an increase of $4.25 per hour for Medicaid personal care reimbursement. The amount of the requested increase is based on the findings of a Clifton Gunderson cost analysis completed for DMAS in fiscal year 1998.
  - Eldon James and William Massey, V4A, presented funding requests to address waiting lists that the area agencies on aging have for in-home care, home-delivered meals, transportation, care coordination, and adult day care and respite care. In addition, a request was made for funding of the Long Term Care Ombudsman program to allow for one ombudsman per 2000 long-term care beds as recommended by the Institute of Medicine.
  - Barbara Allen, Virginia League of Social Services Executives, discussed the goals of adult services as provided by 122 local departments of social services. The five adult services programs include home-based care, community-based care, adult protective services, auxiliary grants, and general relief.
  - Dennis G. Smith, Director of DMAS and Sonia Rivero, Commissioner of DSS, discussed HCFA's decision in March 2000 to discontinue approval of Virginia's Intensive Assisted Living Waiver.
- Public Hearing:
  - Eighteen speakers addressed long-term care issues.

Recommendations of the Long-Term Care Subcommittee

1. **That the Subcommittee Include the Following Broad Issues in its Workplan for 2001:**

- Complete a policy/organizational review of long-term care and aging in the Commonwealth including: what policies have been established; what entities are involved and what are their roles, responsibilities, and authority; what sources of funding are used; and what oversight and coordination is undertaken.

- Examine ways to address nurse staffing shortages including: incentives to enter and remain in nursing, career ladder for nursing assistants, need for and means of compensating for additional training or education, and the availability of Workforce Training Act funding.

- Examine ways in which to better protect residents and enhance quality of care in assisted living and nursing facilities including the possible need for regulation revisions, staffing ratios, enhanced Adult Protective Services and Ombudsman services, and strengthened abuse/neglect reporting requirements and penalties.

- Explore reimbursement issues including personal care and auxiliary grant rates, nursing facility reimbursement, long-term care insurance, asset protection, prescription drug benefits, and Medicaid waivers to provide reimbursement for services that are already provided (care coordination and home-delivered meals) and additional home- and community-based services (including a possible replacement for the Intensive Assisted Living waiver).

2. **That the Joint Commission on Health Care Consider Taking a Lead Role in Working with Public and Private Organizations to Promote a Greater Understanding and Awareness of Critical Health Care and Long-Term Care Issues as a Means of Gaining Broad Public Support for Addressing These Needs in the Future.**

The Subcommittee agreed that in order to address the most pressing health care and long-term care issues, there needs to be a greater understanding of these issues and a greater level of support from the general public, employers, providers, health care organizations, local governments, and legislators. The Subcommittee suggested that the Joint Commission on Health Care consider taking a lead role in generating increased awareness and support of health care issues by working with public and private organizations to: (i) sponsor a conference or symposium on health care/long-term care issues, (ii) initiate a public awareness campaign, and (iii) identify other actions to bring health care issues to the forefront of the Commonwealth's policy debate.

3. **That the Joint Commission on Health Care Introduce the Following Budget Amendments to Support Various Long-Term Care and Aging Services.**

Agency	Services	FY 2002 Funds
Virginia Center on Aging through the Department for the Aging	Statewide Survey of Older Virginians	$240,000 GF
Area Agencies on Aging through the Department for the Aging	In-Home Care (806,500 service-hours)	$9,500,000 GF
	Home-Delivered Meals (1,331,361 meals)	$4,500,000 GF
	Care Coordination (provide service statewide)	$2,500,000 GF
	Long Term Care Ombudsman Positions (1 per 2000 long-term care beds)	$1,500,000 GF
	Transportation (226,860 trips)	$1,250,000 GF
	Adult Day Care and Respite Care (151,188 hours)	$700,000 GF
Department of Medical Assistance Services	Medicaid Personal Care Reimbursement ($4.25/hour increase to $15.50 for most of state, $17.50 for No. Va.)	$7,710,000 GF $8,290,000 NGF
Department of Social Services	Adult Protective Services (full funding of program)	$3,100,000 GF
	Home-Based Care (1,570 individuals)	$2,800,000 GF
Department of Criminal Justice Services	Safe Return Program	$100,000 GF
TOTAL FUNDING		$33,900,000 GF $8,290,000 NGF

4. **That, in Future Years, the Joint Commission on Health Care Introduce Only those Budget Amendments that Are the Direct Result of a Specific JCHC Study.**

APPENDIX C:

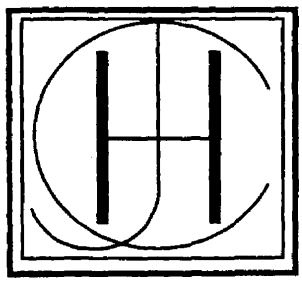
2001 Budget Amendments

JOINT COMMISSION ON HEALTH CARE
BUDGET AMENDMENT REQUESTS*

Description	Requested Amount
DRS: Brain Injury Compliance Monitoring	$20,000
VDH: Brain Injury Compliance Monitoring	$54,000/1 FTE
UVA: Palliative Care	$250,000
VDA: Statewide Survey of Older Virginians	$240,000
VDA: Home Care	$9,500,000
VDA: Home Delivered Meals	$4,500,000
VDA: Care Coordination	$2,500,000
VDA: Long-Term Care Ombudsman	$1,500,000
VDA: Transportation	$1,250,000
VDA: Adult Day Care/Respite Care	$700,000
DMAS: Personal Care Medicaid Reimbursement	$14,682,000 GF $15,626,000 NGF
DSS: Adult Protective Services	$3,100,000
DSS: In-Home Care	$2,800,000
DCJS: "Safe Return" Program for Alzheimer's Patients	$100,000
VDH: Health Workforce Recruitment	$127,000/2FTEs
DHP: LTC Nurse Scholarship/Loan Repayment	$100,000
DHRM: Waive Co-Pay for State Employees for OB Care At Academic Health Centers	$120,000
DMAS: Medicaid Dental Coverage for Adults	$8,200,000 GF $8,847,817 NGF
VDH: African-American Health Assessments	$60,000
VDH: African-American Forum	$15,000
VDH: African-American Disease Prevention	$50,000/1 FTE
DHP: Nurse Workforce Data Collection	$90,000
VEC: Workforce Council/CNA Training	Language
VDH: Pharmacist Scholarship/Loan Repayment	$100,000
VDH: Dental Scholarships	$336,000
VDH: RN/LPN Scholarships	$200,000
VDH: Nurse Loan Repayment	$100,000
DMAS: UVA Indigent Care (COPN)	$2,300,000 GF $2,484,000 NGF
EVMS: Indigent Care (COPN)	$7,100,000
EVMS: Undergraduate Medical Education (COPN)	$952,764
UVA: Undergraduate Medical Education (COPN)	$2,500,000

Description	Requested Amount
VCU: Undergraduate Medical Education (COPN)	$3,000,000
DMAS: Hospital Reimbursement (COPN)	$12,000,000 GF $12,960,000 NGF
VCU: Dental Preceptorship Program	$144,000
VDH: Improve Condition of Dental Trailers	$1,300,000
VHI: Collection of Outpatient Surgical Data	$30,000
VDH: Retain Forfeited Monies for Scholarships/ Loan Repayment Programs	$100,000
DMAS: VCU Indigent Care (COPN)	$12,500,000 GF $13,500,000 NGF

* Because the 2001 Session of the General Assembly did not approve a revised biennial budget, none of the above requests were funded.



Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm