REPORT OF THE
SPECIAL JOINT SUBCOMMITTEE STUDYING

Certificate of Public Need

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 6

COMMONWEALTH OF VIRGINIA
RICHMOND
2001

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EXECUTIVE SUMMARY

Study Origin

This two-year study was initiated in 1998 as a result of a commitment by the Senate Committee on Education and Health to study issues relating to certificate of public need and subsequent consultation between the chairperson of the Senate Committee and the chairmen of the House Committee on Health, Welfare and Institutions. In 1999, the Special Joint Subcommittee obtained formal authorization pursuant to SJR 496 to add citizen members and to continue its study.

The Virginia Certificate of Public Need Program

Virginia's Certificate of Public Need Program, a regulatory mechanism that controls the development of certain health services and facilities, is operated by the Department of Health. A formal application process and due process protections are established in law and detailed in regulation, including requirements for one local public hearing, review by the appropriate regional health planning agency, review by the Department of Health, a final decision by the Commissioner of Health, and the right to appeal the Commissioner's determination.

Virginia's law covers increases in various inpatient beds, introduction of certain new services regardless of site, and the purchase of specified major medical equipment regardless of site. A five-million-dollar capital expenditure threshold authorizes coverage of projects entailing expenditures by or in behalf of a medical facility that are not defined as reviewable in the law. Projects are batched according to categories. Nursing home applications are processed through the Requests For Applications procedure, a mechanism for identifying need according to planning district demographics.

History of Certificate of Public Need in Virginia

Virginia established its certificate of public need law in 1973, approximately one year before the National Health Planning and Resources Development Act of 1974 was passed and required all states to operate certificate of need programs as a condition for receiving certain federal funding. Overbuilding of facilities, duplication of services, and escalating health care costs were the motivating forces behind state and federal efforts to regulate the development of the health care industry in the 1970s.

In the 1980s, the implementation of the Medicare Prospective Payment System and Medicaid cost controls and the philosophical shift to promoting

competition in the health care industry fueled the controversy surrounding certificate of need. In 1986, Congress repealed the federal certificate of need requirement effective on January 1, 1987. In Virginia, this action stimulated several studies of COPN in the 1980s, generating various recommendations.

Among these recommendations, an approved 1989 bill is notable for implementing significant COPN deregulation, e.g., of equipment and certain capital expenditures, and for projecting deregulation of hospitals and ambulatory surgery centers. This bill also levied a codified moratorium on new nursing home beds.

The projected deregulation of hospitals and ambulatory surgery centers did not, however, take place because of being postponed in 1991 and then repealed in 1992. In fact, an approved 1992 bill rendered Virginia's COPN program more comprehensive than it had been before the 1989 partial deregulation, providing coverage of building of facilities, new beds, and initiation of certain new services and purchase of new and replacement major medical equipment for any site.

In 1996, the moratorium on new nursing home beds was lifted and a Request For Applications process was established. Detailed reports on the COPN program are required pursuant to an approved 1997 bill.

In 1998, the Special Joint Subcommittee recommended, and in 1999 the General Assembly approved, elimination of COPN for replacement of any equipment, registration of equipment purchases, and revision of the administrative procedures for review of applications for certificate of public need.

The 2000 Session saw the passage of SB 337 requiring a transition for elimination of the COPN requirements in accordance with a plan to be developed by the Joint Commission on Health Care.

Certificate of Public Need Issues

Certificate of need laws were enacted to address such issues as cost containment, indigent care, quality of care, access to care, consumer involvement, distribution of services, and education of the public in personal care and in the use of the health care system. In the 1970s, overbuilding of facilities was perceived as largely "responsible for the high cost of medical services." The economics of the health care industry of the 1970s have given way to prospective systems based on operating costs or negotiated and contracted rates. Managed care is pervasive in Virginia. Thus, cost containment issues are debated, with both sides presenting arguments for and against the viability of COPN in the age of prospective reimbursement and managed care.

With more than 800,000 Virginians uninsured and private hospitals being the only segment of the health care industry required to provide emergency care and to contribute to the Virginia Indigent Health Care Trust Fund, the questions concerning charity/indigent care are important, especially vis-a-vis the academic medical centers where substantial charity/indigent care is delivered.

Quality of care may be addressed through various regulatory mechanisms, including COPN. The relationship between certificate of need and quality of care is based on two premises, i.e., certificates will be denied to applicants who do not have or cannot obtain the expertise to operate highly sophisticated treatment and testing programs and that patient volume is inexorably linked to quality of care. Certificate of need restricts entry into the market, thus may concentrate services in a smaller number of providers than a free-market environment, and may reinforce the volume-to-quality link.

Certificate of need programs were also predicated on planning principles intended to distribute needed services to appropriate areas and to prevent essential services from withdrawing from needy areas. Service distribution may also be influenced by many factors that are hard to control through regulatory mechanisms.

Consumer involvement is provided by certificate of need through notice to the public of proposed projects, public hearings, and the input of the consumer-controlled boards of the regional health planning agencies.

Work of the Special Joint Subcommittee: 1998

During the 1998 interim, five meeting were held which addressed Virginia certificate of need statistics, the COPN process, the role of the regional health planning agencies, and opportunity for public and stakeholder input and recommendations. The Special Joint Subcommittee also received a literature review on related issues and presentations from the three national accreditation organizations. For the 1999 Session, the Special Joint Subcommittee recommended that certificate of need be eliminated for replacement equipment, that registration of all new equipment purchases be required, that the timelines and procedures for COPN applications be streamlined and specifically delineated, and that the study be continued through an enabling resolution.

Work of the Special Joint Subcommittee: 1999

During the 1999 interim, the Subcommittee operated pursuant to Senate Joint Resolution 496, with six citizen members being added. The Subcommittee again held five meetings during which questions were posed on issues ranging in breadth from the standards used to determine need for outpatient operating rooms

to practice pattern concerns, such as the claim that surgeons who cannot get practice privileges in local hospitals might take advantage of deregulation to establish ambulatory surgery centers.

The Special Joint Subcommittee monitored the implementation of 1999 legislation, obtained up-to-date information on the activities of the regional health planning agencies, reviewed other states' recent certificate of need legislation, received reports from the Commissioner of Health and the Department of Medical Assistance Services, sought information on issues relating to anesthesia in practitioners' offices and outpatient surgical procedures, obtained information on related reimbursement issues, such as facility fees, and received information on the impact of the Balanced Budget Act of 1997 on Virginia's health care providers. Public comment and public and provider participation were also obtained and various legislative alternatives and suggestions were reviewed. In addition, a 50-state telephone survey was conducted relating to certificate of need and health policy.

Fifty-State Telephone Survey: Certificate of Need and Health Policy

Conducted in October and November of 1999, the 50-state Telephone Survey found that 35 states had certificate of need laws of some kind in 1999. One state continued to maintain a § 1122 review process for determining facility need for Medicaid services only. Fourteen states had either repealed their certificate of need laws or allowed their certificate of need laws to expire.

Among the states retaining certificate of need laws, 24 states had programs defined by this survey as "Full-Service" certificate of need laws. Eleven states had restricted certificate of need programs, with seven states covering only long-term care services and facilities, and four other states having other kinds of limited coverage. One of the long-term care states had repealed its law during the 1980s, revived its law in the early 1990s, and reduced its certificate of need coverage to long-term care in 1995.

Among the states without certificate of need laws, eleven states removed certificate of need in the 1980s; three states removed certificate of need from the books in the 1990s; one state removed its certificate of need law in the 1980s, revived the law in the early 1990s, and repealed the law a second time during 1995.

Among the states without certificate of need laws, five state respondents mentioned excess capacity in nursing home beds; five state respondents mentioned hospital concerns; seven state respondents mentioned rural health issues; three state respondents noted increases in ambulatory surgery centers; and three state respondents observed increases in assisted living facilities.

Some of the states without certificate of need programs in 1999 were highly rural and/or sparsely populated or had intensely urbanized populations. These states appeared to have smaller health care systems than Virginia and many rural health care issues as well as generalized access and availability concerns.

Other states without certificate of need programs in 1999 had growing populations and complex health care systems; some states without certificate of need laws had large managed care penetration.

Every state respondent, except one, admitted to health care issues relating to costs or access. No state efforts to monitor or to manage any effects of certificate of need elimination were cited.

Conclusion

The Special Joint Subcommittee collected substantial data and sought the opinions and suggestions of all parties in 1998 and 1999. The Subcommittee's 1998 legislation accomplished significant revisions to the COPN program by eliminating certification for replacement equipment, requiring registration of equipment purchases, and streamlining and delineating the application process. The data collected through the equipment registration process can be used to monitor the trends in Virginia's health care system and could be used to design solutions for unwanted developments.

Many alternative legislative proposals were considered in 1999; however, none of these proposals was endorsed by a majority of the Subcommittee. Although no agreement could be reached, there was strong feeling that the certificate of public need process needs streamlining and could be reduced.

Thus, the Special Joint Subcommittee puts forth this study as documentation of its deliberations in the belief that its work will serve as one of the foundations upon which future General Assembly decisions on Virginia's certificate of public need program may be based.

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THE SPECIAL JOINT SUBCOMMITTEE
TO STUDY
CERTIFICATE OF PUBLIC NEED
TO
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To: The Honorable James S. Gilmore III, Governor of Virginia
and
The General Assembly of Virginia

I. Study Origin

During the 1998 Session of the General Assembly of Virginia, the Senate Committee on Education and Health considered SB 603 (Hawkins). Senate Bill 603, as introduced, related to the elimination of the requirement to obtain a certificate of public need for replacement magnetic resonance imaging (MRI) and elimination of the requirement to obtain a certificate of public need for outpatient or ambulatory surgery centers. The bill, as reported from the Senate Committee on Education and Health, only focused on the magnetic resonance imaging issue; however, during the discussions and motions on the bill, the Committee agreed to examine ambulatory surgery center issues during the 1998 interim. Thus, the Senate Committee on Education and Health made a commitment to examine certain certificate of public need issues that resulted in the convening of this subcommittee.[1]

The Special Joint Subcommittee to Study Certificate of Public Need was initially convened by the chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions, in accordance with the authority granted to standing committees and their chairmen by the Rules of the Virginia Senate and the Rules of the House of Delegates.[2] During the 1998 interim, eight General Assembly members—four members of the House of Delegates and four members of the Senate—served on this special joint subcommittee pursuant to such authority.

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[1] Because certificate of need is the more commonly used name, for the purposes of this report, the terms, certificate of public need (Virginia's program name) and certificate of need, will be used interchangeably. The acronym, COPN, will be used only for the Virginia program.

[2] Rules of the Senate, General Assembly of Virginia, Amended January 15, 1998, Amended January 22, 1998, Rule 20 (h) and Rule 20 (i); Rules of the House of Delegates, General Assembly of Virginia, adopted January 15, 1998, Rule 18 and Rule 22; see Appendix A for text.

Upon concluding the 1998 special study, the Special Joint Subcommittee decided to add citizen members and to recommend enactment of an enabling resolution. Senate Joint Resolution No. 496 of 1999 became that enabling resolution.

Senate Joint Resolution 496 directed the appointment of 14 members to the Special Joint Subcommittee, including the eight legislative members who served on the Special Joint Subcommittee during the 1998 interim, and six citizen members as follows: one physician, one hospital representative, and one long-term care representative, to be appointed by the Senate Committee on Privileges and Elections; one physician, one hospital representative, and one health systems agency representative to be appointed by the Speaker of the House of Delegates. Senator Jane H. Woods served as chairman; Delegates Jay W. DeBoer and Phillip A. Hamilton served as vice-chairmen. Other members so appointed were: Senators Emily Couric, John S. Edwards, and Frederick M. Quayle; Delegates Kenneth R. Melvin and John H. Rust; Mr. Howard P. Kern, Dr. William L. Rich III, Dr. Elizabeth Weick Roycroft, Mr. J. Knox Singleton, Mr. Douglas C. Suddreth, and Dr. H.W. Trieshmann, Jr.

II. The Virginia Certificate of Need Program[3]

Certificate of need is a regulatory mechanism for controlling the development of health care services and facilities. Under this program, the proposal for a health care project must obtain a determination of "need" for the services which hinges on the population demographics, geography of the region, and the existing services in the region.

Complex calculations are made to arrive at the determination of need, using case loads, operating room utilization, occupancy rates, etc. The applications are "batched" in Virginia, according to the category of service or facility. In each locality, a regional health planning agency reviews each application for a project to be located in its area.

A public hearing must be held on each application at the local level. The recommendation, which is advisory, of the regional health planning agency is transmitted to the Department of Health. The Department of Health conducts a review of the application and makes a staff recommendation to the Commissioner of Health, who is charged with making the final decision. Formal hearings are frequently heard on controversial, contested applications; however, many applications are processed without expensive administrative procedures.

[3] Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia; see Appendix B for 2000 law.

Virginia's law covers increases in beds, conversions of beds (with limited exceptions), and some relocations of beds, the introduction of certain new services, and the purchase of certain major medical equipment. Virginia's COPN law requires certificates for covered projects proposed by:

- hospitals, including ambulatory surgery centers;
- sanitariums;
- nursing homes;
- intermediate care facilities;
- extended care facilities;
- mental hospitals;
- mental retardation facilities;
- psychiatric hospitals, including rehabilitation facilities for alcoholics and drug addicts;
- rehabilitation hospitals; and
- physicians' offices.

Thus, certificate of public need regulates:

- centers providing certain specialty services;
- introduction of certain services, regardless of site; and
- purchases of certain new equipment, regardless of site.

Coverage of introduction of new services includes 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, substance abuse treatment, or such other specialty clinical services as may be designated by the Board.

Purchases of any new medical equipment are covered by COPN 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.

Virginia COPN also covers any capital expenditure of five million dollars or more, which is not defined as reviewable in the law and is made by or in behalf of a medical care facility. Capital expenditures between one and five million dollars must be registered with the Commissioner pursuant to regulations developed by the Board.

In Virginia, nursing home bed projects are processed through the unique Requests For Application (RFA) mechanism, a procedure by which the Commissioner of Health, in compliance with Board regulations, identifies need for nursing home beds in the various planning districts and then issues a call for applications for projects in those areas having need.

III. History of Certificate of Public Need in Virginia[4]

The federal Hospital Survey and Construction Act, i.e., the Hill-Burton Act, which was passed in 1946, required a designated agency to submit a state facilities plan. Hill-Burton, the first of many federal health care initiatives, began government regulation of the development and expansion of health care facilities. Enacted immediately after World War II, Hill-Burton was intended to fill the need for hospital facilities and was an important influence on the United States' health care system for approximately 20 years.[5] In Virginia, Hill-Burton generated the earliest health planning documents, i.e., the first State Medical Facilities Plan.

Beginning with Hill-Burton and escalating with the enactment of Medicaid and Medicare and the availability of private sector health benefits, a building boom was initiated in the health care sector. This building boom established the hospital industry in the United States, acknowledged to be among the best in the world. The building boom has often been viewed as a response to the cost-based reimbursement systems of the 1960s and 1970s and is generally recognized by most observers as having resulted in the establishment of duplicative health care services or redundant capitalization. Duplicative services or redundant capitalization have been credited, at least in part, with escalating costs of health care.

As a result of increased building, duplicative services, and escalating Medicare and Medicaid costs, Congress and state legislatures began to examine various regulatory mechanisms. The Social Security amendments of 1972, specifically § 1122, authorized the federal government to condition capital reimbursement funding on state planning laws, i.e., the law required the funded projects to be consistent with the state planning documents. This law conditioned construction cost reimbursement under Medicare, Medicaid, and other programs on state approval of the projects.

In 1973, the General Assembly of Virginia enacted Senate Bill 108,[6] Virginia's initial COPN law. The legislative intent statement included in Senate Bill 108

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[4] This history includes only major changes in or shifts in attitudes toward certificate of public need policy in Virginia; many other bills were approved that were of significant importance to various providers and segments of the health care industry.

[5] Report of the Joint Subcommittee Studying the Feasibility of Preserving a Regional Health Planning Mechanism, *House Document No. 41* at 3 (1983) [hereinafter referred to as *House Document No. 41*].

[6] Chapter 419, 1973 Acts of Assembly, General Assembly of Virginia.

noted that enactment of COPN was an effort to provide for necessary services, to ensure the orderly development of the health care industry, and to curtail the development of duplicative services.

The National Health Planning and Resources Development Act of 1974[7] required states to operate certificate of need programs as a condition for receiving certain federal funding for mental health, substance abuse, and other health programs. This federal requirement for state certificate of need programs was enacted approximately one year after the initiation of COPN in Virginia. Although the exact amount of the conditioned funding is unknown, the sums are assumed to have been significant at the time since all states enacted a certificate of need law or initiated a review program while this federal requirement was in place.[8]

The federal National Health Planning and Resources Development Act established a detailed state health planning system that included a state health plan, a statewide health coordinating council, a state medical facilities plan, a mechanism for drawing the national boundaries for health service areas, and designations of the roles of the state agencies and the regional health systems agencies.[9]

The decade of the 1980s was a time of promoting competition in the health care industry through the implementation of the prospective payment system for Medicare and cost controls for Medicaid. Funding for health planning was on the wane. These developments stimulated the first of many Virginia studies of health planning and COPN issues.

In 1983 and 1984, the Joint Subcommittee Studying the Feasibility of Maintaining a Regional Health Planning Mechanism in the Commonwealth studied a number of issues related to certificate of public need. In 1983, the Joint Subcommittee deferred action. The Joint Subcommittee sponsored 1984 legislation to simplify the COPN process, i.e., authorize only one public hearing at the local level, specify a 90-day review timeline, etc., and to establish state funding for regional health planning activities.[10]

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[7] 42 U.S.C. 300m-2(a) (4) (B).

[8] The program names and mechanisms varied across the country.

[9] The federal Secretary of Health and Human Services drew the lines for the health services areas that were to be served by the regional health systems agencies. From the establishment of the system provided by the National Health Planning and Resources Development Act of 1974 until the repeal of the requirement for certificate of need, Virginia had six regional health systems agencies (HSAs). One of the six regional health systems agencies was located in Tennessee and covered the Counties of Washington and Scott in Virginia and the City of Bristol. After the reduction and subsequent elimination of federal funding for state health planning and the provision of state funds for regional and local health planning, five regional health planning agencies continued to operate in Virginia, with the Southwest Virginia agency subsuming the jurisdictions that had previously been administered from Tennessee. *House Document No. 41*, *supra* note 5 at 4 and Appendix A.

[10] Report of the Joint Subcommittee Studying the Feasibility of Preserving a Regional Health Planning Mechanism in the Commonwealth, *House Document No. 37* at 7 and Appendix F (1984).

The federal requirements for COPN were repealed in 1986 by P.L. 99-660, which became effective on January 1, 1987.[11]

In 1987, then Governor Baliles established, pursuant to Executive Order No. Thirty-one of 1986 (December 19, 1986), a commission to study the Virginia COPN program. This commission's findings included "that, in the present changed health care delivery system, COPN is no longer a viable mechanism for containing health care costs and that it is unlikely deregulation would lead to significant over-expenditure for hospital capital projects; that deregulation may lead to problems of access to hospital care for the rural and inner-city poor populations; that acquisition of major medical equipment and services is important to perceived hospital quality and competition in the market place; and that hospitals should assist government in increasing access of indigent persons to medical care."[12]

In 1989, as a result of the Baliles' Commission's recommendations, the Joint Subcommittee on Health Care for All Virginians proposed significant COPN deregulation. These 1989 recommendations, which were included in SB 762,[13] required immediate elimination of certain capital expenditures and equipment and a projected deregulation of hospitals and ambulatory surgery centers. Section 32.1-102.3:3 called for elimination of the COPN requirement for all facilities licensed as hospitals, including ambulatory surgery centers, on July 1, 1991. Hospitals would have had to apply for a COPN to establish nursing home beds. The moratorium on nursing home beds was also enacted as a statute in this bill—previously, the nursing home bed moratorium had been in uncodified law, i.e., the budget and a section 1 act.[14] This bill called for the Secretary of Health and Human Resources to study the effects of repealing COPN, particularly on access, affordability, and quality of care.

In 1991, HB 1331 postponed the COPN deregulation of hospitals and ambulatory surgery centers to July 1, 1993.[15] House Bill 1331 also extended the nursing home bed moratorium to 1993 and increased the project registration requirements to cover certain specialty services. This bill implemented other recommendations from

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[11] P.L. 99-660 of 1986 repealed Title XV of the Public Health Service Act, the law that had previously required state certificate of need laws.

[12] *Report of the Commission on Medical Care Facilities Certificate of Public Need* (pursuant to Executive Order No. Thirty-one) at 1 (1986).

[13] Chapter 517, 1989 Acts of Assembly, General Assembly of Virginia.

[14] Chapter 493, 1981 Acts of Assembly (HB 1452), General Assembly of Virginia, levied a moratorium on nursing home beds, with certain limited exceptions relating to health and safety and other factors, from July 1, 1981, to June 30, 1982. Chapter 198, 1982 Acts of Assembly (HB 879), General Assembly of Virginia, extended this moratorium. The Appropriation Act for 1988-1990, Item 374 of Chapter 800, 1988 Acts of Assembly (HB 30), General Assembly of Virginia, also established a general moratorium on certificates for one year, i.e., July 1, 1988, to June 30, 1989. In 1989, Senate Bill 762 provided for deregulation of equipment and for delayed effective deregulation of hospitals and ambulatory surgery centers while placing a statutory moratorium on nursing home beds.

[15] Chapter 561, 1991 Acts of Assembly, General Assembly of Virginia.

the Secretary of Health and Human Resources (for example, authority to condition approval of certificates on agreements to provide indigent care), who was directed to continue his extensive study of the COPN process pursuant to the second enactment of HB 1331; the continuing study also focused on the effects of deregulation. At this time, the Commonwealth was coping with poor economic conditions and budget issues. The increasing cost of health care to the state (Medicaid and the state employees' benefits, for example) was an important budget issue. Thus, HB 1331 was based on the findings of the Secretary that "the certificate of public need program should not be abolished during the 1991 session of the General Assembly and that many organizations have been reassessing prior adverse positions on the COPN program."[16]

In 1992, upon the recommendation of the Secretary of Health and Human Resources, the Commission on Health Care for All Virginians proposed, and the General Assembly approved, HB 1188.[17] This measure provided for extensive revisions of the COPN law, including repeal of the scheduled 1993 hospital and ambulatory surgery center deregulation. Thus, in the period between the enactment of Virginia's original COPN law in 1973 and 2000, notwithstanding the 1989 planned deregulation, Virginia's COPN law has remained in effect. Further, hospitals and ambulatory surgery centers have been continuously covered by the COPN law in Virginia.

With the passage of the 1992 legislation, Virginia's COPN program became more comprehensive than prior to the planned deregulation, covering building of facilities, new beds, initiation of certain new services, purchase of new and replacement major medical equipment by hospitals, doctors' offices, and other medical facilities, and maintaining the nursing home bed moratorium.

In 1996, pursuant to the recommendation of the Joint Commission on Health Care, the moratorium on new nursing home beds was lifted and a Request For Applications process for new nursing home beds was established pursuant to HB 1302.[18] The RFA process remains in effect at this time, i.e., applications, with

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[16] *Final Report on the Virginia Medical Care Facilities Certificate of Public Need Program of the Secretary of Health and Human Resources* at 79 (November 15, 1990); see also *Preliminary Report of the Secretary of Health and Human Resources on the Virginia Medical Care Facilities Certificate of Public Need Program* at 132-133 (August 22, 1990).

[17] Chapter 612, 1992 Acts of Assembly, General Assembly of Virginia.

[18] Chapter 901, 1996 Acts of Assembly, General Assembly of Virginia, revised the moratorium law, i.e., § 32.1-102.3:2, which was first established by Chapter 517 of 1989, and directed the Joint Health Care Commission to study COPN regulation of outpatient or ambulatory surgery centers and the possible application of COPN regulation to adult care residences providing assisted living and intensive assisted living levels of care. Two other approved 1996 bills, Chapters 531 and 849, 1996 Acts of Assembly, General Assembly of Virginia, revised existing exceptions and provided for two new exceptions to the moratorium, with enactment clauses providing for the expiration of the amendments and the continuation of the Commissioner of Health's authority to proceed on the applications filed pursuant to the exceptions. Twenty subdivisions providing exceptions to the moratorium on submission, acceptance, and approval of applications for nursing home beds were enacted from 1991 to 1996.

several exceptions, must be filed in response to the Commissioner's request for applications and can only be filed for locations within jurisdictions determined by the Commissioner to have need for new beds.[19]

Beginning in 1997, pursuant to HB 2477--another Joint Commission on Health Care recommendation, the Commissioner of Health has been required to submit detailed annual reports on the COPN programs.[20] These reports focus on different aspects of the program and must be scheduled to cover the entire program over a period of five years.

In 1999, as a result of the work of the Special Joint Subcommittee to Study Certificate of Public Need, the Virginia COPN law was amended to eliminate the requirement for a certificate of public need for the replacement of any equipment;[21] to require registration with the Commissioner of Health and the appropriate health planning agency, within 30 days of becoming contractually obligated, of purchases of any medical equipment for the provision of cardiac catheterization, computed tomographic scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging, magnetic source imaging, open heart surgery, positron emission tomographic scanning, radiation therapy, or other specialized service designated by Board regulation; and to revise the administrative procedures for review of applications for certificate of public need.[22]

During the 2000 Session, the General Assembly discussed many COPN bills and approved several important measures, i.e., two identical bills, Senate Bill 25 (Stosch) and House Bill 613 (Nixon), eliminated the COPN requirement for the introduction of cardiac nuclear imaging services or the purchase of equipment to deliver cardiac nuclear imaging services.

House Bill 1270 (Rust) adjusted the various timelines and procedures for issuance or denial of a certificate of public need.

Senate Bill 337 (Martin) requires a transition for elimination of the COPN requirements for determination of need to begin on July 1, 2001, and to be completed by July 1, 2004. This transition to deregulation is to be accomplished according to a plan that is to be developed by the Joint Commission on Health Care and submitted to the General Assembly in 2001.

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[19] Continuing Care Retirement Community nursing home bed projects are excepted by statute if the application is for the lesser of 60 beds or 20 percent of the total number of beds that are not nursing home beds. These beds are automatically provided a one-time, three-year open admission period. In addition, Senate Bill 596 of 2000 provides an exception to the RFA process for an increase of 60 beds in a nursing facility in Giles County that will be dedicated to the provision of skilled nursing, hospice services, and care of persons with Alzheimer's and related diseases (Chapter 859, 2000 Acts of Assembly, General Assembly of Virginia).

[20] Chapter 462, 1997 Acts of Assembly, General Assembly of Virginia.

[21] Some equipment replacement had been previously exempted.

[22] Chapters 899 and 922, 1999 Acts of Assembly, General Assembly of Virginia.

IV. Certificate of Public Need Issues

The federal National Health Planning and Resources Development Act of 1974 mentioned such issues as primary care, medically underserved populations (rural and economically depressed areas), multi-institutional systems, group practices, sharing of support services, improving access, development of various levels of care, prevention of disease, uniform cost accounting, simplified reimbursement, utilization reporting, improved management, and education of the public in personal care and in the use of the health care system. Ironically, many of the issues presumed addressed by this 1974 federal law remain major concerns in 2000, e.g., cost containment, indigent care, quality of care, access to care, consumer involvement, distribution of services in medically underserved areas, prevention, utilization review, and education of the public in personal care and in the use of the health care system.

Cost Containment

Overbuilding of facilities during the 1960s and 1970s was perceived as being largely "responsible for the high cost of medical services."[23] One important factor in this scenario is that fee-for-service reimbursement for physician and institutional services was the accepted approach during the 1960s and into the late 1970s. As a result of increased building and increasing health care costs, Congress and state legislatures began in the 1970s to examine various regulatory mechanisms, including certificate of need. The 1974 federal certificate of public need requirements were intended to establish the orderly planning of health systems to meet the "needs" of the defined population and to restrict the overbuilding of facilities, frequently referred to as redundant capitalization or redundant services.

The economics of the health care industry have significantly changed since 1974. Public and private reimbursement systems have shifted from cost-based and retrospective systems to prospective systems based on operating costs or negotiated and contracted rates. Some of the major changes in reimbursement patterns and methodologies are:

- The initiation of the prospective payment system for hospitals, based on diagnosis related groups (DRGs) by Medicare in 1984.
- The initiation of the Patient Intensity Rating system (PIRS) for reimbursement of nursing homes by Virginia Medicaid on the basis of four classes of patient functioning status.

[23] *Goodin v. State Ex Rel. Okl. Welfare Commission*, 486 F. Supp. at 586 (1977).

- The growth of managed care in both the public and private health care benefits programs, e.g., the state employees' health care program was converted to a managed care system in 1992. [24]
- The implementation of Medicare's Resource Based Relative Value Scale (RBRVS) physician fee schedule (MFS) for reimbursement of physicians in 1992.
- The revision and reduction of Medicare payments to hospitals and other health care providers that are being implemented pursuant to the Balanced Budget Act of 1997.

As the 21st century begins, many mechanisms are commonplace that were virtually unknown in the 1970s, for example, primary care gatekeepers for referrals to specialty care, utilization review, preauthorization of services, and medical necessity determinations. Profit margins are down, surgery and other services have shifted to less costly, outpatient settings. Various sectors of the health care industry are seeking opportunities to improve their revenues.

Opponents of certificate of need assert that cost containment is no longer an issue vis-a-vis certificate of need because managed care and prospective payment systems now control costs. The opponents of certificate of need also contend that reimbursement changes and managed care have removed the incentives to establish redundant services.

These opponents also maintain that physician-directed demand for services is no longer a factor in cost control because of current requirements for referrals, preauthorization of services, medical necessity determinations, and utilization review.

Proponents of certificate of need reason that the competition for paying patients and revenue streams, such as facilities fees and reimbursement for outpatient surgery and cancer treatment and high technology testing, have shifted the incentives to establish redundant services from the inpatient setting to the outpatient setting.

Proponents of certificate of need aver that managed care and prospective payment systems will not be able to contain health care costs without a planned approach to capital expenditures and distribution of services. Proponents also claim that more providers of services always result in more services being delivered and more costs being incurred.

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[24] Section 1-22, Department of Personnel and Training, Item 61, Chapter 723, 1991 Acts of Assembly, General Assembly of Virginia (House Bill 1150), required the Director of the Department of Personnel and Training to present a plan by October 1, 1991, to revise the employees' health benefits plan. Certain managed care components were to be considered, most of which were incorporated into this system during the following year.

Charity/Indigent Care

With more than 800,000 Virginians uninsured,[25] many of whom are young and/or employed in industries that frequently do not provide health care benefits, health care delivery to the indigent and uninsured is an important and ongoing issue. The question of who provides care to the indigent and uninsured is also important.

Hospitals receiving Medicare and Medicaid--virtually all hospitals--are the only sector of the health care industry that is required by federal law to treat any patient who presents with an emergency.[26] The Emergency Medical Treatment and Active Labor Act, which was intended to prevent the "dumping" of indigent patients by some hospitals on other hospitals, particularly on academic health care centers, is cited as evidence that hospitals deliver the bulk of indigent care. In addition, hospitals note their 24-hour-a-day accessibility through emergency rooms and that emergency rooms commonly operate at a loss. Emergency rooms are still used, by some patients, as the only source of care, and emergency room patients must often be admitted to the hospital for treatment.

In addition, acute care hospitals are required to participate in the Virginia Indigent Health Care Trust Fund by law; no other providers are required to participate in this program.[27] This program collects and redistributes contributions from acute care hospitals and state appropriations on the basis of provision of charity care, i.e., those hospitals providing less charity care pay more into the Fund and the hospitals delivering significant amounts of charity care may receive payments from the Fund. This program, it is said, redistributes only a small percent of the total cost of hospitals' charity care.[28]

Hospitals also declare that Medicare, which is a significant source of hospital revenues, has curtailed the rates paid to hospitals and others substantially during the past 20 years. Hospitals cite Virginia's low Medicaid rates as recouping approximately 79 cents to the dollar for hospital care and call attention to community expectations for delivery of such expensive services as burn units and pediatric and obstetrical services. To be able to continue providing expensive services expected by the community and vital to public health, hospitals state that revenue generating services must be maintained.

Physicians and free-standing treatment centers are not required by law to deliver charity care and only ambulatory surgery centers, which are required to be

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[25] Joint Commission on Health Care Staff Analysis, *1993 and 1996 Health Access Surveys*.

[26] The Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1983dd, establishes a duty for hospitals to treat patients who present with emergencies or in active labor.

[27] Chapter 11 (§ 32.1-332 et seq.) of Title 32.1 of the Code of Virginia.

[28] For information provided by the Department of Medical Assistance Services during 1999 on the Virginia Indigent Health Care Trust Fund, see Appendix G.

licensed in Virginia as hospitals, report the value of their charity care (ambulatory surgery centers do not contribute or participate in the Indigent Health Care Trust Fund). Therefore, although acute care hospital data is collected and reported to the Indigent Health Care Trust Fund and ambulatory surgery center data is reported to Virginia Health Information, Inc., no comprehensive data is compiled on the total amount of indigent care delivered by the various components of Virginia's health care industry. Hard data on physician and free-standing center delivery of indigent care is not available. Much anecdotal information is, however, recounted.

Physicians do not dispute that hospitals render much charity care. Nonetheless, physicians note that few physicians would turn any patient away, regardless of ability to pay. Physicians also point to low Medicaid reimbursement and concerns about managed care and other reimbursement changes. They state that physicians have demonstrated their willingness to shoulder part of the charity care burden.

Physicians emphasize that, for every patient provided charity care in a hospital, one or more physicians are involved in the delivery of treatment at the hospital. These physicians may provide care for such patients from their offices for long after hospital discharge. Many specialty physicians assert also that they provide significant charity care to patients in their offices as a result of referrals.

Quality of Care

Quality of care is addressed through various mechanisms, including COPN, accreditation of facilities, licensure of facilities and professionals, and certification for reimbursement.

The relationship between certificate of need programs and quality of care is based on two premises, i.e., certificates will be denied to applicants who do not have or cannot obtain the expertise to operate highly sophisticated treatment and testing programs and that patient volume is inexorably linked to the quality of care.

Various studies, including recent analyses, have indicated that quantity and quality of health care are related.[29] These studies have examined indicators such as morbidity and mortality, i.e., patient outcomes. These studies provide strong evidence that quantity and quality are closely related and experience and practice with complex procedures are assumed to increase skill and improve expertise. It must be noted, however, that these studies do not cover every complex procedure or every provider delivering the treatment and do not prove that all programs with small volumes deliver poor quality care or produce higher rates of poor outcomes.

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[29] "Volume of Primary Angioplasty Procedures and Survival After Acute Myocardial Infarction," John G. Canto, Nathan R. Every, David J. Magid, William J. Rogers, Judith A. Malmgren, Paul D. Frederick, William J. French, Alan J. Tiefenbrunn, Vijay K. Misra, Catarina I. Kiefe, Hal V. Arron, *The New England Journal of Medicine*, Vol. 342, No. 21 (May 25, 2000).

Opponents of COPN declare that the increasing shift of surgery and other care to outpatient delivery and the dramatic improvements in medical technology and pharmacology already mean that highly technical procedures and tests are more available and accessible to patients in lower volume practices without creating any obvious decline in patient confidence or the quality of care in Virginia.

Proponents of COPN commented during this study that maintaining quality of care is a primary function of the Virginia COPN program, i.e., by ensuring adequate patient volumes to ensure professional experience and expertise that translate into higher quality of care and greater public safety.

Access to Care

Certificate of need programs were predicated on planning principles that were intended to distribute needed services to appropriate areas and prevent essential services from withdrawing from needy areas. Access to care may, however, be influenced by factors, which are difficult, if not impossible, to control, such as practitioners' personal economic conditions and goals, lifestyle preferences, and practice decisions, e.g., rural versus urban location and participation in Medicare and Medicaid. Further, availability of services may not translate into access to care. Patient access to care may, for example, depend on availability of charity care, whether the patient has insurance or whether the patient's insurance covers the needed service or whether a specific provider participates in the patient's insurance program.

Opponents of COPN claim that access to care will be improved by allowing the free-market development of services and single-site delivery of comprehensive services. The COPN opponents point out that patients may believe access to care means that the treatment is available in their community. Certificate of need opponents also claim that the demographics of certain areas of the state may be such that the development of freestanding treatment centers would be desirable from a continuum of care perspective, e.g., cancer treatment available in the patient's community and comprehensive ophthalmic specialty service available at a single site. For patients who find travel difficult or inaccessible, the opponents of COPN assert that availability of care at a location requiring such travel may not be synonymous with access to care.

Proponents of COPN aver that, without COPN to control the distribution of services across the Commonwealth, services will clump in affluent suburban and urban areas and that providers will leave economically depressed inner cities and rural, sparsely populated areas where economic factors are not favorable. The COPN proponents also argue that some populations--even some affluent populations--may not be large enough to support multiple delivery of the same

services; therefore, some hospitals may be forced to close unprofitable service units to remain solvent or reduce the delivery of indigent care and other hospitals may be forced into insolvency, perhaps into closing.

Consumer Involvement

The National Health Planning and Resources Development Act of 1974 established a formal system of regional health planning throughout the country. In Virginia, this mechanism for health planning has been maintained.[30] Virginia presently has five regional health planning agencies. Each of these agencies is governed by a board of no more than 30 local citizens, a majority of whom must be consumers of health care. These local citizen boards also represent providers, local health departments, local social services departments, local community services boards, area agencies on aging, health care insurers, local governments, the business community, and the academic community. Appointments may be made by local governments and professional, service, and academic entities or nominations may be solicited from the public. Regional health planning agencies' duties include such functions as data collection, research, analyses, identifying gaps in services, and reviewing applications for certificates of public need and making recommendations to the Department of Health concerning the COPN applications.[31]

The regional health planning agencies receive COPN applications and must, as part of the review of the applications, hold one public hearing in the local area on each application. Notice of the public hearing must be published in a newspaper of general circulation in the locality of the proposed project at least nine days before the public hearing. The applicant is also given an opportunity to respond to any comments included in the planning agency staff report. Controversial projects frequently receive heavy media coverage in the locality.

Thus, the public is provided information about proposals for local changes or additions in health care services and an opportunity to comment on these proposals at a public hearing. Since consumers of services must constitute the majority of members of the local citizen boards, these consumers are involved in the health services recommendations of the localities and have input in the health planning decisions of the region.

Opponents of COPN do not object to consumer comment or involvement in this process, which has often been favorable to the development of outpatient and free-standing services. Proponents of COPN assert that this is a unique public information and involvement mechanism that should be preserved in order to promote citizens' knowledge of and interest in local health care services and the stability of the health care system.

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[30] Article 4.1 (§ 32.1-122.01 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.

[31] Section 32.1-122.05 of the Code of Virginia.

V. Work of the Special Joint Subcommittee: 1998

During the 1998 interim, the Subcommittee held five meetings, including one public hearing. Much information was presented to the Joint Subcommittee concerning the certificate of need in Virginia, including COPN statistics, the COPN process, the role of the regional health planning agencies, and opinions concerning COPN's effects on access to and availability of care, quality of care, and health care costs.

In addition, alternative regulatory mechanisms were discussed including accreditation processes and organizations, licensure, and deemed status. Certificate of need's relationship to cost containment in the Virginia Medicaid program was also examined. A stake-holder survey was conducted, i.e., the health care community and the public at large were invited to respond to a Call For Proposals on the issues relating to certificate of public need. The responses to this invitation were summarized and used in the decision-making process.[32]

Specifically, the meetings were designed to include historical and background information and data on the COPN program, especially as related to ambulatory surgery. This data included legislative history, program statistics, and excerpts from the Department of Health's annual report. The regional health planning agencies, the Medical Society of Virginia, Virginia Hospital and Health Care Association, and all other interested parties were encouraged to provide their perspectives.

The Special Joint Subcommittee was reminded that expansion of managed care has sparked interest across the county in reexamining COPN requirements, e.g., New Jersey has lifted its COPN requirements for initiation of pediatric and maternity service, while keeping the requirement for highly specialized services, such as transplantation and neonatal intensive care units.

Statistics and other information relating to the operation of Virginia's Medical Care Facilities Certificate of Public Need Program were also presented. For example, the numbers of operating rooms in general hospital and ambulatory surgery centers, the number of procedures performed, and hours of usage were detailed from 1995 to 1997 according to the health planning region and planning district.[33] In addition, the Special Joint Subcommittee received an inventory of ambulatory surgery centers and their utilization. These data demonstrated a general increase in the numbers of procedures performed in operating rooms across the Commonwealth, with some reductions and slow growth also noted.

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[32] See Appendix C for 1998 study agendas, public hearing announcement, and call for proposals.

[33] See Appendix F for operating room data presented by the Department of Health in 1998.

Many, if not most, general hospitals have outpatient surgery services and much surgery is performed in practitioners' offices. This trend can be attributed to expansion of managed care, the growth of technology, e.g., highly sophisticated eye surgery that takes only a short time to perform, and the shifts in reimbursement that encourage and favor less-costly procedures. The Special Joint Subcommittee was also told that general hospitals and ambulatory surgery centers are treated the same way for purposes of establishing need for additional operating rooms. The criteria include utilization of present operating rooms, such as numbers of procedures performed and number of hours of usage.

The Special Joint Subcommittee was also informed that Virginia's COPN program is well-considered in the country for its equity and its level playing field because the same standards apply to all applicants. The COPN program has been repeatedly evaluated by the legislative and executive branch levels. Further, it was stated, supply and demand economics do not work in the health care arena. Several instances of relaxation of COPN laws were given in which the numbers of relevant procedures dramatically increased, necessitating the reapplication of the COPN requirements.

Costs of some services are going to be lower if the number of providers of the service is small, e.g., MRI services, because the price must include the capital costs for providing the service. The costs of out-patient surgery are generally significantly higher than in-patient surgery. In any case, most facilities do not report the price by procedure because of possible variations according to the time or complications, etc. The costs of in-patient hospital stays are impacted by the complexity of the procedure, the costs of indigent care, and the necessity of maintaining intricate and expensive support systems, such as emergency rooms.

Some of the questions posed by the Special Joint Subcommittee for consideration during 1998 related to the standard for determining operating room utilization; urban congestion, transportation, and distance issues; rural distribution and access problems; the costs of COPN to applicants; and the relationship to providers and patients of reimbursement issues, such as facility fees as a component of reimbursement for Medicare patients.

A night public hearing was held to provide physicians, administrators, associations, organizations, and patients the opportunity to be heard. All interested parties were invited to present on a first-come first-served basis in order of sign-up after the release of the public hearing notice. The Department of Health provided significant data and information and the Department of Medical Assistance Services provide information on the Indigent Health Care Trust Fund.

Using a unique and unprecedented format, the Special Joint Subcommittee invited the three national accrediting organizations, i.e., the Joint Commission on Accreditation of Health Care Organizations (JCAHCO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), and the Accreditation Association for Ambulatory Health Care (AAAHC) to appear and present their processes and how these procedures provide safeguards for the quality of care.

Research was conducted into other states' recent certificate of need actions, econometric analyses of the impact of COPN on the health care system, i.e., costs of care, cost containment, Medicaid/Medicare costs, etc. Information on Medicare reimbursement and its possible or current effects on facility growth or change was also sought. National legislative organizations, such as the National Conference of State Legislatures, were also used as resources for information.

Study Objectives

In 1998, the Special Joint Subcommittee, as a standing committee-directed study, did not have written directives from a passed or introduced resolution. Therefore, the Special Joint Subcommittee set its own objectives consistent with the actions during the 1998 Session, as follows:

- To examine all aspects of the issues relating to the requirement for obtaining a certificate of public need for providing outpatient or ambulatory surgery.
- To examine all aspects of the issues relating to the requirement for obtaining a certificate of public need for purchases of major equipment to provide certain services, e.g., computed tomographic (CT) scanning, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), and positron emission tomographic (PET) scanning.
- To examine such other issues relating to certificate of public need as may be relevant.
- To provide an opportunity for input from all relevant constituencies.
- To seek assistance from state agencies or other sources as may be necessary.
- To make recommendations to the Governor and the 1999 General Assembly concerning the certificate of public need program.

Literature Review[34]

Most commentators agree that the market in the 1970s, at the time of establishment of certificate of need laws, was supplier driven, and that the fee-for service reimbursement systems of the time provided incentives for delivery and

[34] The literature review conducted in 1998 has been supplemented with more recent cites in some instances; however, the points made have not been altered.

development of services that may not have been needed. Experts also tend to agree that there has never been a truly competitive health care market, i.e., a market in which supply and demand dynamics work and consumers know and understand the product sufficiently to make discerning choices. The fact is that most consumers do not have the knowledge or the objectivity to make technical decisions on treatment or providers. In addition, there is also general acknowledgement that health care providers and services are not distributed evenly across Virginia or the nation and that maldistribution of services contributes to differences in prices, quality, and access to care.[35] Beyond these concepts, there is very little agreement.

Studies of the effects of certificate of need often focus on containment of health care costs or reduction in bed capacities and do not attempt to analyze the effects on access to care, quality of care or public involvement. These studies use a variety of anecdotal, survey, and national, mostly Medicare, data. Contradictory conclusions are reached by the studies, rendering opinions on certificate of need controversial.

A 1998 published study indicated that certificate of need programs reduced beds by two percent and acute care expenditures by nearly five-percent per capita; however, this same study did not find a corresponding opposite statistical result from eliminating certificate of need.[36] Data from this study suggested a surge in hospital care when certificate of need is lifted, based on Medicare Part A expenditures; however, no surge in capital expenditures was detected after elimination of certificate of need.[37] Other studies have indicated that where there are more acute care beds there is more utilization of hospital care and physicians' practice styles control utilization of surgery and clinical testing.[38]

In late 1989, however, following Virginia's planned repeal and general reduction in the scope of COPN, expenditures for equipment and new services were reported as significantly increased. Howard Cullum, then Secretary of Health and Human Resources, is quoted as saying that half of the $130 million spent by hospitals in the period of partial deregulation between 1989 and 1992 would have been denied under the previous COPN program.[39] Secretary Cullum also stated that Virginia had more magnetic resonance imaging equipment than Canada.[40]

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[35] "Cooperative Care," Bill Edwards, *Virginia Business* at 39-44 (September 1998) [hereinafter referred to as "Cooperative"].
[36] "Cooperative," *supra* note 35 at 42.
[37] "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" Christopher J. Conover and Frank A. Sloan, *Journal of Health Politics, Policy and Law*, Vol. 23, No. 3 at 455-481 (June 1998).
[38] "Cooperative," *supra* note 35 at 42.
[39] "Rebirth of a good idea," Linda Wagar, *State Government News* at 21 (June 1992) [hereinafter referred to as "Rebirth"].
[40] "Rebirth," *supra* note 39 at 21.

Even in 1989, however, the role of certificate of need programs in this age of managed care was being questioned, as Medicaid and private insurance implemented managed care programs. In fact, some officials are reported to have believe that the two forces "cannot live together," while other commentators, although acknowledging difficulties in refuting this concept, believe that this concept is incorrect and point to certificate of need's role in maintaining quality of care.[41]

Managed care's ability to contain costs is also the subject of controversy. A study of cost shifting to private-pay patients in California acute care hospitals indicates that California's low Medicaid reimbursement for acute care pushed such hospitals into such cost shifting and that, contrary to expectations, competition and managed care did not "influence" the cost shifting.[42] Conversely, researchers found that, in Florida, "cost shifting was limited by extensive penetration by HMOs into the market, an above-average number of for-profit hospitals, and Medicare's status as the largest third-party payer in the state."[43] A recent article on managed-care medical directors noted the conflicting goals and roles, i.e., containing costs, improving quality, and limiting unnecessary treatment.[44]

Another recent article on the effects of public policy on the health care industry and system notes that important changes take place after deregulation, i.e., repeal of certificate of need or a rate-setting mechanism. For example, this study reported incidents of increased mergers and other restructuring actions and cultural shifts from cooperation to competitive relationships focused on increasing referrals and volumes. This study also reported that institutions with certificates of need sometimes use their certificates to leverage competitive benefits, e.g., by negotiating with managed care to provide high tech services or using their certified operation of high tech services to increase their acquisition value to multiple institution systems.[45]

One paper provided comments relating to certificate of need's role in assessment, noting the studies that document variations in health care delivery according to geographic regions and the existence of redundant services. This paper also described certificate of need as "one of the few institutional forums for public

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[41] "CON and Managed Care: Can the Concepts Coexist?" *State Health Notes*, Intergovernmental Health Policy Project, Vol. 28, No. 249 at 1 (March 31, 1997) [hereinafter referred to as "CON and Managed Care"].

[42] "Dynamic cost shifting in hospitals: Evidence from the 1980s and 1990s," Jan P. Clement, Ph.D., *Inquiry 34* (Winter 1997/98).

[43] "New Wine in Old Bottles: Certificate of Need Enters the 1990s," Robert B. Hackey (University of Massachusetts), Duke University, *Journal of Health Politics, Policy and Law*, Vol. 18, No. 4 (Winter 1993) [hereinafter referred to as "New Wine"].

[44] "Executives with White Coats -- The Work and World View of Managed-Care Medical Directors: Second of Two Parts," Thomas Bodenheimer, Lawrence Casalino, *The New England Journal of Medicine*, Vol. 341, No. 26 (December 23, 1999).

[45] "Rules of the Game: How Public Policy Affects Local Health Care Markets," Loel S. Solomon, *Health Affairs*, Vol. 17, No. 4 at 140- 148 (1998) [hereinafter referred to as "Rules"].

participation in health policy decision making" and increasing provider accountability to communities.[46]

Regardless of the contradictory information available about the effectiveness of certificate of need, there appears to be a "major trend . . . toward deregulation" in the United States vis-a-vis both certificate of need and rate setting programs.[47] The deregulation trend is evinced by the fact that only one state, i.e., Maryland, now has a rate-setting mechanism and by the repeal or expiration of certificate of need laws in fourteen states and the reduction of certificate of need laws in eleven other states. This trend is said to be "counterbalanced by a wide range of policies aimed at curbing the perceived excesses of the market."[48]

Public Comment and Stake Holder Survey

In August 1998, the Special Joint Subcommittee held a night public hearing to provide maximum access to providers, associations, and the public for input into the study process.

Although no speaker claimed to be representing the viewpoint of all members of any group or organization, presenters provided a spectrum of perspectives ranging from consumers, health planning agencies, physicians, hospitals, and academic medical centers.

Two presenters, speaking as consumers of health care, noted the increased convenience and reduced cost of having eye surgery in ambulatory surgery centers. Both patients were Medicare beneficiaries who noted that the handling of claims through these facilities was also simpler than with hospitals while the training of the personnel and quality of the operating rooms were the same as in hospitals. One gentleman, who has arthritis, spoke to physical access difficulties and described his concerns about walking distances and parking spaces.

Three physicians presented various viewpoints. For example, one physician, speaking for academic health centers, stated that he thought the study of the costs of health care services to the indigent and uninsured should be completed and that this issue should be resolved before certificate of public need was changed. He also spoke about cost shifting in hospitals in terms of revenue-generating versus revenue-losing services and maintenance of the less cost effective services. Another physician, speaking for a hospital system, noted decreasing profit margins in hospitals and the various forces in the health care system such as managed care. Another physician, speaking for a surgery group, said that managed care now controls the costs of health care and that the rate of increase in health care costs

[46] "New Wine," *supra* note 43 at 933.
[47] "Rules," *supra* note 45 at 145.
[48] "Rules," *supra* note 45 at 141.

has declined. He also stated that ambulatory surgery centers will not run up costs, that more creativity is needed in the delivery of care to achieve more for less, and that physicians want the indigent/uninsured problem resolved as witnessed by their contributions to such care.

Several speakers described the issues as costs of care, charity/indigent care, quality of care, access to care, and public involvement. Several speakers spoke to other states' actions on certificate of need, i.e., outright repeal or expiration of laws, piece meal reductions in the laws, and exceptions or exemptions.

Several hospital administrators spoke to the certificate of need process and the need to move cautiously to preserve hospitals' ability to provide charity care and the viability of the academic medical centers. Accessibility was said to be improved by planning and efficient use of operating rooms was equated to the time such rooms were in use. Outpatient surgery was described by one speaker as the "bread and butter" service for hospitals. This speaker also stated that, if COPN is repealed, the loss of outpatient surgery cases through physicians referring patients to their ambulatory surgery centers would hold nonprofit hospitals "hostage" to physicians' decisions. Several of these speakers averred that ambulatory surgery centers have few indigent care patients and do not take "risky" patients. The consensus among hospital representatives was that COPN should be maintained at this time.

In September, the Special Joint Subcommittee announced the opportunity for all interested parties to submit concise written proposals relating to any Virginia laws relevant to certificate of public need and regulation of health facilities by October 15. These proposals were then paraphrased and presented to the Subcommittee at the November meeting. The public was informed that the written proposals could involve specific amendments or alternatives to any relevant state law, alternatives or amendments to the COPN law or other health facility law, and any other changes or suggestions, including that there be no change in specific law. Responders were also encouraged to consider the impact of their suggestions on access to health care, funding of indigent care, and the development of an efficient and effective health care system in Virginia. Eleven responses were received.

Dr. Robert M. Regan of Prince William Health System responded to the question posed by the Subcommittee during the public hearing concerning the viability of requiring ambulatory surgery centers to contribute to the Indigent Health Care Trust fund. He noted that such requirement would generate some funding for indigent care, but would not provide any incentives for delivery by the ambulatory surgery centers of indigent care to local patients. Hospitals, he stated, would still be required to provide surgery care, regardless of ability to pay. He also noted the uneven playing field in competing with ambulatory surgery centers because emergency cases often interrupt operating schedules.

Dr. Jack A. Carroll, President, Sheltering Arms Physical Rehabilitation Hospital, included a resolution adopted by the Board of Directors of Sheltering Arms, noting that repeal or limitation of COPN would mean a proliferation of specialty centers with no responsibility for caring for indigent patients. Dr. Carroll's letter notes that 100 percent of the responsibility for sicker patients would be transferred to hospitals, undermining their ability to support such services as emergency rooms and obstetrical units, services that are part of the continuum of healthcare but are expensive. Dr. Carroll states that new market entrants—in the event of repeal of COPN—would not select these less profitable areas. He also noted his belief in COPN as critical to the provision of healthcare regardless of ability to pay.

Ms. Mary Lynne Bailey, Vice President for Legal and Government Affairs, the Virginia Health Care Association, expressed the belief of her members that COPN has served Virginia well in maximizing access to care, controlling health care costs, and developing an efficient and effective health care system. For nursing beds, she stated that COPN is essential for Medicaid fiscal integrity, bed distribution, efficient use of resources and controlling the cost of care, attracting proven providers, and preventing the development of a two-class system, i.e., one for private-pay patients and one for Medicaid-reimbursed patients. Ms. Bailey noted that, even in states without COPN, there are usually controls on nursing beds and that quality of care can suffer in the unstable financial environment resulting from proliferation of nursing facilities. She asked that the recently established Request For Applications process for new nursing facility beds be allowed to develop before any changes are made to the nursing bed requirements of COPN.

Ms. Katharine M. Webb, Senior Vice President, Virginia Hospital and Healthcare Association, praised the goals of COPN, i.e., " to promote comprehensive planning to meet the health needs of the public, at the lowest reasonable cost, avoiding unnecessary duplication of facilities." She noted the roles of hospitals and health systems in organizing and delivering care as major employers and as public policy activists, and described the debate over COPN as centering on the delivery of care to the underinsured, uninsured or poor. She also described emergency rooms, obstetrical services, and burn care units as essential health services requiring support from other more profitable service lines. She stated the belief that repeal of COPN for ambulatory surgery centers will mean the fragmentation of the health care system, with specialists leaving the hospitals for ambulatory surgery centers. She wrote that requiring ambulatory surgery centers to contribute to indigent care "will not solve the essential services problem." She also noted that, although the Association advocates no change in the law, they did support revision/improvement of the process, particularly the length of the review process when hearing officers are involved. She suggested that the law be amended to provide that, if a decision

is not rendered within the then 120-day legal requirement, the project would be deemed to be approved.

Mr. Paul L. Kitchen, Executive Vice President, The Medical Society of Virginia, wrote emphasizing the Medical Society's opposition to COPN, particularly in regard to the requirement of certificates for ambulatory surgery centers. He detailed and countered the arguments that have been made during the previous meetings and the public hearing concerning the impact on hospitals and health systems of the repeal of the certificate requirement for ambulatory surgery centers. For example, as to the hospital industry's contributions to indigent care, he noted that the Medical Society did not dispute this assertion and pointed out that physicians accept responsibility for caring for the same patients and may well continue such care well beyond the hospital discharge. He also described physicians' contributions to free clinics and long history of indigent care. Mr. Kitchen committed the Medical Society to development of "alternative approaches to indigent care funding that are equitable to all providers and accessible to all patients," which may include "participation in the Indigent Health Care Trust Fund, structured contributions to local indigent care needs as a precursor to licensure, formal referral arrangements with traditional community providers of indigent care, or enhanced participation in the Medicaid program through the implementation of medical facility fees for outpatient and ambulatory surgery centers." He stated that the trend towards outpatient surgery is driven by "changes in the marketplace, changes in third party payment policies, and changes in technology." He averred that retention of COPN for outpatient and ambulatory surgery centers "will only hinder the market driven perfusion and adaptation of these new technologies and efficiencies."

Mr. Jerry Tillinger, Administrator, Orthopaedic Surgery Centers, wrote that COPN served to "shape the landscape of the health care community" during the time of cost-based reimbursement. However, he stated that the market has changed with Virginia's strong managed care environment and that the law is now questionable. He particularly noted the difficulties with obtaining COPNs for major medical equipment as favoring hospital-based units and objected specifically to the requirement for obtaining a COPN for replacing equipment.

Ms. Marcia A. Melton, Director of Public Policy, Virginia Association of Nonprofit Homes for the Aging (VANHA), stated that recent market reforms have caused shifts in service delivery and noted that managed care requires health service organizations to reduced costs and create new efficiencies. In long-term care, new payment mechanisms, federal regulatory changes, increases in the availability of residential facilities and home care, and changing consumer demands have affected the system. Therefore, she stated that VANHA questions the "continuation of COPN for nursing facilities." VANHA believes in a free market, allowed to drive the development, and "that consumers should no longer be limited

to nursing home bed availability." VANHA officially "supports the elimination of the Certificate of Need Process and the Request for Application Process for nursing facilities." Ms. Melton suggested coupling elimination "with a new Medicaid reimbursement system based on the level of services and quality of care delivered to individual residents."

Mr. Dean Montgomery, President, Virginia Association of Regional Health Planning Agencies, provided detailed background on COPN in Virginia, particularly noting the effects of the partial repeal in 1989 and the swift reaffirmation of COPN in 1992. He also stated that, over the years, the program has been scaled back to cover "those services where the effects and implications appeared to be great." Mr. Montgomery set out the three major categories of projects that are subject to COPN, i.e., nursing home beds, hospitals in new locations and major services within hospitals, and outpatient surgical, diagnostic imaging, and radiation therapy services. He wrote that COPN is necessary to contain expenditures and service utilization, to enhance quality, to maintain the viability of community hospitals, and to promote access for low-income patients. Without COPN, he predicted that surgery facilities and imaging facilities will increase significantly, surgeries and imaging procedures will have similar increases, less efficiency and higher costs per procedure, large increases in surgery and imaging expenditures, increased risks to quality of care, disparity in patient populations, and substantial losses of profits by community hospitals that serve large Medicaid and uninsured populations. He provided 14 points relating to the negative effects of repeal of COPN for ambulatory surgery centers and imaging centers, e.g., more surgeries and imaging and, therefore, increased costs, virtually no delivery of charity care in such centers, the strain on hospital finances and the consequences for charity care, and that Medicare is "addressing the payment differential that has resulted in the patient's co-payment being higher at hospitals than at freestanding settings. . . . This will reduce and then eliminate any differential in patient co-payments." He also averred that minor surgery that is presently performed in physicians' offices will migrate to ambulatory surgery centers "where the costs and reimbursement are substantially higher."

Mr. Paul M. Boynton, Executive Director, Eastern Virginia Health Systems Agency, recommended, in his letter, that no substantial changes be made in the present COPN law "other than perhaps eliminating from COPN review requests to replace such diagnostic equipment as CT scanners." He recommended that COPN for ambulatory surgery centers not be eliminated and noted the difference in the overhead costs between ambulatory surgery centers and hospitals and the resulting differences in costs. He stated that poor patients often go to emergency rooms for care and frequently wait until they are very sick—thus requiring more costly care. Charity patients, he noted, do not go to ambulatory surgery centers. He also responded that managed care is not a "magic bullet" and that general inflation has a direct effect on the Medical Care Index. On the managed care side, he said that

HMO/managed care plans have no interests in paying for indigent care and medical education and that the diversion of outpatient surgical volume from hospitals will reduce hospitals' ability to pay for indigent care and medical education. Mr. Boynton also wrote that deregulation of ambulatory surgery centers could mean the transfer of procedures routinely performed in medical offices without facility reimbursement to the ambulatory surgery centers. He described the relationship between surgical volumes and outcomes and stated that accreditation does not ensure that ambulatory surgery centers have the caliber of quality control as hospitals because of mandatory peer review in hospitals.

Dr. Inderjit Singh of Glen Associates concisely stated in his letter that COPN currently adversely impacts "growth of ambulatory surgery centers that can result in cost savings to consumers and payers." He stated that there is insufficient diversity in providers in Virginia in order to promote competition to lower costs and charges and promote quality of care and financial and geographic access. He mentioned that there is no conclusive evidence that ambulatory surgery center regulation has had a significant impact on the health care system and that the reimbursements, technology and higher standards of care have had more positive effects. He asked for removal of COPN for ambulatory surgery centers.

Dr. H. W. Trieshmann of Orthopaedic Surgery and Sports Medicine Specialists of Hampton roads (Magnetic Resonance Imaging Center) pointed out, in his letter, that surgery in ambulatory surgery centers is less expensive than hospital outpatient surgery. He also stated that safety and quality of the care are "at least comparable." His letter described the two principal concerns as increases in surgeries and indigent care. He said that managed care would control any excess volume of procedures and that indigent care cannot be provided in hospitals without physicians. He wrote that it is illogical to "state that hospitals need to be given special consideration because they provide indigent care while physicians do not receive the same consideration although we also provide the indigent care." He stated that ambulatory surgery centers would increase the physicians' ability to provide indigent care. He noted that "a reasonable charge could be determined for ambulatory surgery centers which could go to an indigent care fund of some type." He ended his letter by stating that patients would be the greatest beneficiaries "of allowing ambulatory surgery to be performed in doctor's offices."

Accreditation

During the 1998 study, the Special Joint Subcommittee received presentations from three national accrediting organizations, i.e., the Joint Commission on Accreditation of Health Care Organizations (JCAHCO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), and the Accreditation Association for Ambulatory Health Care (AAAHC). The Special Joint Subcommittee requested the testimony of these organizations with

particularly emphases on the relationship between accreditation and deemed status under Medicare for hospitals and ambulatory surgery centers and the criteria for accreditation of hospitals and ambulatory surgery centers as these criteria relate to quality, access, and the availability of care. "Deemed status" means that accreditation by an approved organization will be accepted as "reasonable assurance" that the conditions for participation in Medicare are being met by the accredited facility, thereby exempting the accredited facility from the federal certification survey that, in Virginia, is conducted by the Department of Health. Deemed status has recently been accorded by some states in the form of recognition for licensure. Deemed status could be used for other regulatory purposes.

Accreditation Organizations and Procedures

The Joint Commission on Accreditation of Health Care Organizations (JCAHCO) accredits hospitals, ambulatory care facilities, nursing homes, home health care organizations, health care networks, clinical laboratories, and mental health facilities. Accreditation surveys are conducted at least every three years for hospitals and ambulatory surgery centers. Under Virginia law, hospitals certified by JCAHCO are only subject to state inspections "to the extent necessary to ensure the public health and safety."[49]

JCAHCO's assessment of its member organizations focuses on functional areas (patient rights, patient care, continuum of care, the environment of care, leadership, management of information, infection control, human resources, and organizational ethics). Standards are developed with input from health care experts, providers, purchasers, consumers, government officials, and measurement experts. These standards address performance expectations affecting the quality of patient care and outcomes. In addition to the period surveys, JCAHCO conducts "focused surveys" to monitor deficiencies, random unannounced surveys, complaint surveys, sentinel event investigations (unexpected death or serious injury or risk thereof), and other for-cause surveys. Complaints may be filed with JCAHCO by anyone; all complaints are processed—some may receive only a written response, others result in a survey of the relevant facility or organization. Full surveys include public interviews with the survey team. JCAHCO also operates a service known as "Quality Check," providing free reports on the accredited organizations. Performance reports are also now available to the public on all member organizations. JCAHCO employs full-time survey personnel.

Among the standards for ambulatory surgical centers, JCAHCO includes anesthetic risk and evaluation (a requirement that the physician evaluate the risk of anesthesia and the relevant procedure to the patient immediately before surgery and evaluate the patient for proper anesthesia recovery before discharge). Administration of anesthetics must be performed by a qualified anesthesiologist or

[49] § 32.1-125.1 of the Code of Virginia.

a physician, certified registered nurse anesthetist, anesthesiologist's assistant or supervised trainee in an approved educational program. In addition, each ambulatory surgery center must have a recovery room which is separate from its waiting room, specific equipment is required in an emergency room (such as tracheotomy sets, laryngoscopes, cardiac monitoring equipment, emergency drugs, etc.), and standard emergency personnel must be available to the patient at all times and must include people trained in the use of emergency equipment and cardiopulmonary resuscitation (CPR).

The organizations accredited by JCAHCO are accorded "deemed status" for the purposes of Medicare certification for reimbursement (participation) by the federal Health Care Financing Administration.

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) accredits only surgery facilities. AAAASF was established in 1992 but was formerly known as the American Association for Accreditation of Ambulatory Plastic Surgery Facilities, which was founded in 1980. AAAASF inspects all accredited facilities initially and thereafter on a three-year cycle. AAAASF requires that all surgeons using the facility be board certified or board eligible. The facility director must be a board certified surgeon or anesthesiologist. All surgeons in the facility must hold valid and unrestricted hospital practice privileges at a nearby hospital for the procedures that are performed within the facility. Only those procedures for which hospital privileges are held may be performed by the surgeons in the facility. Each multi-specialty center must have a written transfer agreement with a nearby hospital for transfer of patients requiring inpatient treatment. All facilities are required to participate in peer review and quality assurance programs.

If a physician has his hospital practice privileges restricted or limited by any hospital, is found in violation of a code of professional ethics, has his licensure limited, suspended, terminated or otherwise affected, is disciplined by the state medical board or fails to report any of these infractions, AAAASF may deny or revoke the facility's accreditation.

Facilities are accredited according to a set of "facility classes," i.e., Class A—only local or topical anesthesia; Class B—local or topical anesthesia and/or intravenous or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia; Class C—local or topical anesthesia, and/or intravenous or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia, and/or endotracheal or laryngeal mask intubation or inhalation anesthesia administered by an anesthesiologist or certified nurse anesthetist.

AAAASF maintains 10 aspects or categories of standards for accreditation; each standard has a detailed check list of requirements for the inspectors. These categories may be broadly denoted as the facility's physical layout, patient and personnel records, peer review and quality assurance, operating room personnel, equipment, operations and management, and sanitation of the operating room suite or office complex. The standards and checklist manual addresses these aspects or categories as: general environment or environment, policy and procedures; recovery room environment, policy and procedures; general safety in the facility; blood and medications; medical records; quality assessment/quality improvement; personnel; and governance. The AAAASF standards are very detailed and specific, e.g., maintenance and cleaning requirements and sterilization requirements are noted and peer review is required at least every six months and must include random case review and review of unanticipated operative sequelae. AAAASF inspections are performed by one board-certified surgeon, chosen from a list of three potential inspectors nominated by the association. The inspectors volunteer their time and expenses. No inspector is allowed to review a facility in his own community. Reciprocal inspections are not allowed.

The AAAASF will give provisional accreditation to a facility; however, AAAASF requires a number of surgeries to be performed by the surgeons before an inspection for full accreditation is scheduled. Approximately 20 to 25 facilities have not been able to meet AAAASF's standards. AAAASF has recently been accorded deemed status by the Health Care Financing Administration.

The Accreditation Association for Ambulatory Health Care (AAAHC) accredits various kinds of ambulatory health care facilities, including ambulatory surgery centers, student health centers, physicians offices and surgical suites, diagnostic imaging centers, occupational health facilities, radiation oncology centers, medical groups, managed care organizations, oral and maxillofacial surgeons and dental groups, community health centers, and endoscopy centers. Twelve member organizations, representing the various accredited facilities, compose the AAAHC governing board. AAAHC has eight core standards and 15 adjunct standards. The eight core care standards relate to the rights of patients, governance of the organization, administration of the organization, quality of care, quality management and improvement, clinical records, professional improvement and facilities and environment. The adjunct standards relate to the various specialty centers, i.e., diagnostic imaging services, radiation oncology treatment, occupational health services, other professional and technical services, teaching and publication activities, research activities, managed care professional services delivery organizations, anesthesia services, surgical services, overnight care and services, dental services, emergency services, immediate/urgent care services, pharmaceutical services, and pathology and medical laboratory. The standards outline the accreditation requirements, for example, sterilization and cleaning of operating rooms and transfer arrangements for patients requiring inpatient care.

AAAHC conducts surveys of its member organizations using volunteers who are professionals actively engaged in ambulatory care after a careful selection process with ongoing peer review and refresher courses. Surveyors are matched to similar specialties and/or settings. AAAHC maintains a surveyor training and education committee to monitor this process. A presurvey questionnaire is required, with supporting documents and a list of materials for onsite review. The survey team meets with the facility operators, tours the facility, conducts an opening conference, and then inspects the facility. During the survey, the team reviews the governance and administrative documents, clinical records, and quality improvement program. Individual interviews are conducted and a summation conference concludes the survey. After the survey, the team prepares a report on the visit and staff of AAAHC and its accreditation committee review the report.

Various levels of accreditation may be awarded, i.e., three-year accreditation, one-year accreditation, provisional accreditation, or a deferral of accreditation. Accreditation may also be denied. Accreditation by AAAHC is accorded "deemed status" for purposes of Medicare certification for reimbursement by the federal Health Care Financing Administration.

1998 Special Joint Subcommittee Recommendations

Following due consideration and discussion, the Special Joint Subcommittee recommended that:

1. Certificate of Public Need be eliminated for all replacement equipment.
2. Registration of all new equipment purchases be required.
3. The timelines and procedures for COPN applications be streamlined and specifically delineated.
4. The study be continued through an enabling resolution.

These recommendations were realized through the passage of two identical bills, Senate Bill 1282 (Woods) and House Bill 2369 (Rust). The Special Joint Subcommittee became a formal study through the approval of Senate Joint Resolution No. 496 of 1999. [50]

VI. Work of the Special Joint Subcommittee: 1999

During its 1999 deliberations, the Special Joint Subcommittee posed numerous questions on many issues, ranging in breadth from issues relating to the 1980s use of a reasonable cost standard based on data collected by the state at the time; the validity of the economic threat of increases in outpatient surgery capacity

[50] See Appendix D for copies of the signed bills, i.e., chapters, and approved resolution.

to community hospitals; the assumption that surgeons who cannot get practice privileges in local hospitals would take advantage of deregulation; the effectiveness of the licensure procedures in ensuring quality of care; the impact of COPN on access to care; the current operating room volume standards and the applicability of these standards in today's managed care environment; patient demographics and mixes in various outpatient settings (indigent, working poor, Medicare, Medicaid, insured, uninsured, etc.); the differences in surgery costs in freestanding centers and hospitals; the need to maintain hospital inpatient surgery services; consumers ability to assess the costs and quality of health care and make informed decisions concerning health care services; the potential for fragmentation of the health care system; patient convenience in the scheduling and timing of procedures/delays in obtaining care; and the impact of COPN on quality of care, e.g., use rates, mortality and morbidity rates.

The Special Joint Subcommittee conducted five meetings during the 1999 interim that were focused on providing the new citizen members with a review of the 1998 study and the 1999 legislation of the Special Joint Subcommittee and seeking answers to its questions. The Subcommittee also monitored the implementation of the 1999 legislation, obtained up-to-date information on the activities of the regional health planning agencies, reviewed other states' recent certificate of need legislation, received reports from the Commissioner of Health on the status of Virginia's COPN program and from the Department of Medical Assistance Services on the Virginia Indigent Health Care Trust Fund, sought additional information on issues relating to anesthesia in practitioners' offices and outpatient surgical procedures, and received information on the impact of the Balanced Budget Act of 1997 on Virginia's health care providers. The Special Joint Subcommittee also received much public comment and public and provider participation and reviewed various legislative alternatives and suggestions. In addition, a 50-state telephone survey was conducted relating to certificate of need and health policy.[51]

1999 Virginia Certificate of Public Need Legislation

For the 1999 session, the Special Joint Subcommittee recommended that COPN be eliminated for all replacement equipment and that registration of all new equipment purchases be required. The Subcommittee also recommended the streamlining and delineation of the timelines and procedures for COPN applications. The Subcommittee's recommendations were enacted as HB 2369 (Chapter 922) and SB 1282 (Chapter 899). This legislation included the following provisions:

- The administrative procedures statute was amended to require the Board of Health to establish concise procedures for prompt review of applications;

[51] See Appendix E for 1999 study agendas.

application fees of one percent of the proposed expenditure for the project are to be imposed with a minimum of $1,000 and a maximum of $20,000; applicants are to transmit the application by certified mail or a delivery service, return receipt requested, or deliver the document by hand, with signed receipt to be provided.

- The 120-calendar-day review period was set to begin on the date upon which the application is determined to be complete within the batching process or, if the application is not determined to be complete within 40 calendar days from submission, the application must be refiled in the next batch for like projects.

- The application review by the health systems agencies must be limited to 60 calendar days; the health systems agency must submit its recommendations on each application and its reasons within 10 calendar days after the completion of its 60-calendar-day review or such other period the applicant has requested. If the health systems agency does not complete its review within the 60-calendar-day period or the period requested by the applicant and submit its recommendations within the 10 calendar days after the completion of its review, the Department of Health, on the 11th calendar day after the expiration of the health systems agency's review period, must proceed as though the health systems agency has recommended project approval without conditions or revision.

- The Department and the Commissioner must begin the review of the application upon receipt of the completed application and simultaneously with the review conducted by the health systems agency.

- The Administrative Process Act will only apply to the COPN process in those instances for which timelines and specifications are not delineated in the COPN law, e.g., a formal hearing procedure.

- Upon accepting an application as complete, the Department must establish a date for every application between the 80th and 90th day within the 120-calendar-day review period for holding an informal fact-finding conference, if necessary. The Department must review every application on or before the 75th day within the 120-calendar-day period to determine whether an informal fact-finding conference is necessary; any informal fact-finding conference will be to consider the record and not a de novo review.

- In any case in which an informal fact-finding conference is held, a date must be established for the closing of the record, which date must be not more than 45 calendar days after the date of the conference. In any case in which an informal fact-finding conference is not held, the record must be closed on the earlier of the date established for holding the conference or the date that the Department

determines no conference is necessary; if the Commissioner's determination is not made within 15 calendar days of the closing of the record, he must notify the Attorney General and copy the parties and persons petitioning for good cause standing, in writing, that the application must be deemed approved unless the determination is made within 40 calendar days of the closing of the record.

- In any case in which the determination is not made within 40 calendar days after the closing of the record, the Department must refund 50 percent of the fee, the application will be deemed approved, and the certificate must be granted. If a determination is not made within 15 calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications may, prior to the application being deemed approved, institute a proceeding for mandamus against the Commissioner; if the writ of mandamus is granted, the Department will be liable for the costs and reasonable attorney's fees.

- Upon the filing of a petition for mandamus, the relevant application will not be deemed approved, regardless of the time between the closing of the record and the final decision. Deemed approvals will be construed as the Commissioner's case decision on the application pursuant to the Administrative Process Act and will be subject to judicial review on appeal as provided in the APA.

- The Commissioner's annual report on COPN must include an analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department. The analysis must detail 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 within the timelines, the number of deemed approvals from the Department because of its failure to comply with the timelines, any other data determined by the Commissioner to be relevant to the efficient operation of the program, and an analysis of the equipment registrations, including the type of equipment replaced and purchased and the equipment costs.

Among other activities, the 1999 study included monitoring the implementation of all 1999 Virginia COPN legislation. Therefore, several other approved bills, although not recommendations of the Special Joint Subcommittee, should be noted.

House Bill 2314 (Baker)[52] was a recommendation of the Joint Commission on Health Care. This bill eliminated certificate of public need for the replacement of certain diagnostic imaging equipment, including computed tomography, positron

[52] Chapter 920, 1999 Acts of Assembly, General Assembly of Virginia.

emission tomography, and magnetic source imaging. This bill did not conflict with the Special Joint Subcommittee's recommendations, but was subsumed by the Special Joint Subcommittee's bills that eliminated COPN for all replacement equipment and required registration of all equipment purchases requiring certificates.

House Bill 2543 (Ruff)[53] required the Board of Health's regulations to establish specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in these areas and providing for weighted calculations of need based on the barriers to health care access in such rural areas in lieu of the determinations of need used for the particular proposed project within the relevant health systems area as a whole. This bill required the Commissioner to include, within his consideration of the need that the population served or to be served by the project has for the project, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care. The Commissioner was also required to include, in his assessment of the efficiency and appropriateness of the use of existing services and facilities in the area that are similar to the proposed project, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

House Bill 2080 (Baker)[54] required the Commissioner of Health to reassess the Request For Applications (RFA) methodology for determining need for an increase in the nursing home beds in the various planning districts. Specifically, House Bill 2080 required the Commissioner of Health to determine the nursing home bed need in the relevant planning districts without counting those beds that were authorized, but not yet built and licensed. If the Board of Health's criteria for need would have been met under this determination, the Commissioner was also empowered to accept applications and authorize projects in the relevant planning districts.

Study Objectives

Senate Joint Resolution No. 496, the Special Joint Subcommittee's 1999 enabling resolution, directed the Subcommittee to examine the following issues in second year of its study:

- Whether the certificate of public need program fulfills the goals of ensuring quality and access to health care services and containing costs by preventing the duplication of costly and unnecessary services;

[53] Chapter 926, 1999 Acts of Assembly, General Assembly of Virginia.
[54] Chapter 912, 1999 Acts of Assembly, General Assembly of Virginia.

- The effects of elimination of any certificate of public need requirements on access to care for the uninsured and underinsured in the Commonwealth;

- The interaction of modern health care financing; specifically, various forms of managed care with the certificate of public need program;

- Alternative regulatory or legal mechanisms that could be developed to provide accountability, access to care, quality assurances, and public input in the development of health care services, and to prevent redundant capitalization;

- Whether any part or all of the certificate of public need law should be repealed or if any segment of the health care industry which is presently covered by this law should be treated in a different manner;

- Any other issues relating to the certificate of public need law and its relationship to the health care industry and patient needs.

State and Local Review Activities

The Department of Health reported on implementation activities related to various 1999 COPN legislation, including the Special Joint Subcommittee's recommendations. The Board of Health approved emergency regulations on July 23, 1999, to implement certain provisions of several 1999 bills. Backlogs of final decisions were being reduced and a third hearing officer had been appointed to assist in this process. The impact of the Special Joint Subcommittee's legislation was described as establishment of a sanctioned review process and deregulation of replacement of all medical equipment. The Department committed to having emergency regulations in place to implement the sanctioned review process in time for the October 10, 1999, review cycle.

Emergency regulations to effectuate the 1999 amendments requiring special consideration for projects proposed in rural areas and weighting of project review standards for such projects were approved by the then acting Commissioner of Health on behalf of the Board of Health in July and became effective 30 days after publication in the *Virginia Register of Regulations*. The State Medical Facilities Plan was also being amended to be consistent with the rural special consideration regulations.

Another approved bill required, for the purpose of issuing Requests For Applications (RFAs) for increases in nursing facility beds, the discounting of certain approved increases in nursing facility beds when the particular beds had not yet been built. Analysis of the nursing facility bed need in all planning districts utilizing this restriction did not identify any need for additional beds. The Board of Health approved the release of the nursing home bed needs analysis on July 23,

1999. The Department's recommendation to the acting Commissioner of Health and the Board of Health was, at this time, not to issue additional Requests For Applications for increases in nursing home beds in the identified planning districts. The Department did, however, review the comments on the nursing home bed needs analysis and reconsider this recommendation based on these comments.

A summary of recent regional health planning agencies actions was provided on behalf of the Virginia Association of Regional Health Planning Agencies. The regional planning agencies noted recommendations for various approvals or denials and stated their belief that the COPN program, including the planning controls on licensed surgery facilities and services, strikes a reasonable balance and is generally responsive to and protective of the public interests.

The health planning agencies reported that the shift to outpatient, less costly surgery does not seem to have been affected by COPN and has been dramatic in Virginia. Although nationally approximately 50 percent of surgery performed in licensed facilities is outpatient, in Virginia, about 66 2/3 percent of the procedures performed in licensed surgery facilities is outpatient, with many hospitals having close to an 80 percent outpatient rate and some regions of Virginia approaching a 75 percent outpatient rate.

In the past decade, the demand and facilities for surgery have increased between 40 to 45 percent; however, the use pattern reflects that the average number of procedures performed per licensed operating room has increased by 4 percent during the past 12 years (733 procedures per operating room in 1987; 763 procedures per operating room in 1998).

The health planning agencies noted that apparently licensed surgery facilities, including ambulatory surgery centers, may be more efficiently used in Virginia than in other areas, with the average number of surgery procedures per licensed operating room being higher in Virginia than nationally and in neighboring states. Thus, the health planning agencies reported their conclusion that effective use of capacity reduces overhead costs and contains average surgery costs and charges which are somewhat lower in Virginia than in other states.

The health planning agencies also stated that adding unnecessary capacity to any health care service has resulted in increased costs and decreased quality. Outpatient surgery, the Association reported, was already available and convenient for both patients and practitioners. Thus, the planning agencies believed that removing COPN from ambulatory surgery facilities could do significant harm to community hospitals.

The health planning agencies asked that (i) the persons requesting the elimination of COPN from surgery facilities be identified and their interests

defined, (ii) the economic threat of increases in surgery capacity to community hospitals be assessed, (iii) the issues relating to the delivery of charity care be addressed, and (iv) the efficiency and cost effectiveness of hospitals and freestanding surgery centers be examined. The planning agencies reiterated the relationship between volume and quality of outcomes.

Anesthesia in the Practitioner's Office

The Special Joint Subcommittee also received information concerning anesthesia services in various surgery settings in Virginia, including some facts concerning a well-publicized Northern Virginia disciplinary case. Answers to members' questions were provided by the president of the Virginia Society of Anesthesiologists.[55] The guidelines of the American Society of Anesthesiologists for office-based anesthesia were estimated to be issued in October or November 1999. In addition, the Health Care Financing Administration's study of anesthesia issues was in process in 1999.

The Subcommittee was instructed that the goal of the anesthesiologists is to develop a rational approach to the delivery of anesthesia services through the guidelines. The monumental shift of surgery to the outpatient setting and the current controversy in Florida concerning rules relating to office-based surgery were reviewed.[56]

There are three levels of anesthesia, depending on the type of surgery, i.e., topical anesthesia and local and regional blocks (using drugs that affect local areas or produce small field blocks, thus having small risk); conscious sedation/sedation anesthesia (using drugs to induce a level of consciousness at which the patient can tolerate unpleasant sensations without loss of defensive reflexes, thus producing a moderate degree of risk); and general anesthesia (using drugs that affect the whole body and act on the brain to induce loss of consciousness, thus producing greater risks). The Special Joint Subcommittee inquired about the standards, particularly accreditation requirements, which might be appropriate for offices, etc. The policies and procedures for patient histories and pre-procedure examinations, obtaining consent and providing information, monitoring of patient signs, infection control, recovery rooms, safety equipment, discharge criteria, etc., were reviewed. Levels of

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[55] Dr. Patrick Clougherty, then President of the Virginia Society of Anesthesiologists, provided expert testimony on anesthesia.

[56] Newspaper articles reported that, in a two-year period, Florida experienced at least a dozen deaths resulting from office surgery performed under general anesthesia. "Cosmetic Surgery: The Hidden Dangers--Lack of regulations heightens surgical risks," *Sun-Sentinel*.com (November 25, 1998) <http://www.sun-sentinel.com/news/daily/detail/0,1136,7500000000040989,00.html>. "Cosmetic Surgery: The Hidden Dangers, " Fred Schulte and Jenni Bergal, Staff Writers, *Sun-Sentinel*.com (November 26, 1998) <http://www.sun-sentinel.com/news/daily/detail/0,1136,7500000000041032,00.html>. "Problems with anesthesia during cosmetic surgery sparking debate," Fred Schulte and Jenni Bergal, Staff Writers, *Sun-Sentinel*.com (February 6, 1999) <http://www.sun-sentinel.com/news/daily/detail/0,1136,9000000000039265,00.html>.

training and supervision for the various levels of anesthesia and practitioner qualifications were also discussed.

In Virginia, the Board of Dentistry has extensive regulations concerning the use by dentists of anesthesia in their offices. The Board requires specific training and experience for certification to deliver the various levels of anesthesia in the office setting. Two dentists provided the Subcommittee with a review of these requirements which are consistent with the recommendations/guidelines of the American Dental Association and considered to be stringent.

No other Virginia health regulatory board requires, at this time, its licensees to adhere to practice standards in office settings such as those promulgated by the Board of Dentistry.

Reimbursement

Reimbursement through various third-party payment systems impacts the configuration and delivery of health care services. Third-party reimbursement may be for professional services, i.e., physicians and other practitioners for treatment or surgery, and may also pay a facility fee for hospital services, i.e., operating rooms, patient rooms, etc.

Medicare is the nation's largest health care benefits program, covering approximately 65 million people who are over the age of 65 or disabled or who have end-stage renal disease (ESRD). Part A of Medicare covers hospital costs, in accordance with the prospective payment system (PPS)--a system relying on categories of diagnoses, known as diagnosis related groups (DRGs). Medicare pays for very little long-term care, except for skilled care post-hospital discharge for 90 days. Part B of Medicare covers physicians, outpatient care and other services. Part B services do not fall under the PPS. Office visits and professional costs are reimbursed at 80 percent for providers accepting assignment (participating in Medicare), with the beneficiary paying the other 20 percent. Thus, the less expensive the care, the less copayment the beneficiary must pay and the more important costs become to Medicare patients. Some health insurance also calls for copayments, either on a percentage or flat rate basis.

Facility fees are paid to facilities that are licensed, such as hospitals, ambulatory surgery centers, and specialty centers, and, in the case of Medicare, only those facilities that are certified for reimbursement by the federal government. Physicians' and other practitioners' offices are not licensed in Virginia by any state regulatory agency. Although many surgical procedures are performed in physicians' and other practitioners' offices, Medicare and private insurance will not pay facility fees for such surgery.

In Virginia, the Department of Health licenses hospitals, including ambulatory surgery centers that are licensed as specialty hospitals. Virginia requires projects for hospitals, ambulatory surgery centers, many specialty services, and major medical equipment to obtain a certificate of public need; therefore, licensure and certification for Medicare reimbursement for these projects hinge on the COPN process.

In Virginia and across the nation, the changes to the prospective payment system initiated by the Balanced Budget Act of 1997 have been heralded as the largest reimbursement cuts to hospital and other providers yet implemented. Hospital analysts predict more than a 10 percent reduction in aggregate payments to hospitals by Medicare. In addition, Virginia Medicaid payments are being cut. As a result of these reductions, the hospital analysts also predict the compounding of the economic stresses from upward wage pressures, which have been caused by personnel shortages (for example, nurses). Increases in drug costs are also factors causing decreases in profit margins, because hospitals are reimbursed a fixed amount per case according to the DRG which includes pharmaceuticals and supplies, etc.

The pressures from managed care and changes in Medicaid and Medicare reimbursements have also impacted other providers and created competition in the health care industry for patients and for the facility fees as well as the professional fees.

VII. Fifty-State Telephone Survey: Certificate of Need and Health Policy[57]

A 50-state telephone survey was conducted in October and November of 1999. The survey determined if the state still had a certificate of need program and, if not, when the law was repealed or expired.[58] In states having certificate of need programs, each state respondent was asked to identify the CON-regulated facilities, services, and equipment and any expenditure thresholds. When relevant, each respondent was asked to make observations concerning certificate of need deregulation or phase-out. All respondents were asked to make observations about current trends in health care, the effects of any changes in health policy or any influences on the health care industry that may be currently occurring. All fifty states were contacted; states' responses were used in the analysis.

To provide a foundation for determining any national trends, a summary of the certificate of need laws in effect in 1995 was compiled to provide a broad comparison with the certificate of need laws in effect in 1999.

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[57] See Appendix H for PowerPoint Presentation on telephone survey.
[58] Please note, the state respondents' information on repeal or expiration was accepted as fact.

1995 State Certificate of Need Laws

In 1995, 39 states had certificate of need laws, i.e., Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Minnesota's certificate of need law expired on June 30, 1984, and was revived as a general program for a short period in the early 1990s. Although Minnesota's certificate of need program was in effect (at least on paper) for part of 1995, it had been "dropped" again by the end of 1995. Wisconsin also repealed its certificate of need law in the 1980s and revived a general certificate of need program in the early 1990s and reduced the program to coverage of long-term care in 1995.[59]

One state, Louisiana, has maintained a § 1122 review process for determining facility need for Medicaid services only. Louisiana never enacted a certificate of need law.

By 1995, 10 states had either repealed their certificate of need laws or allowed their certificate of need laws to expire, i.e., Arizona, California, Colorado, Idaho, Kansas, New Mexico, South Dakota, Texas, Utah, and Wyoming.

1999 State Certificate of Need Laws

In 1999, 35 states had certificate of need laws of some kind, i.e., Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Louisiana continued, in 1999, to maintain a § 1122 review process for determining facility need for Medicaid services only.

By 1999, 14 states had either repealed their certificate of need laws or allowed their certificate of need laws to expire, i.e., Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, and Wyoming. The four states that eliminated their certificate of need laws between 1995 and 1999 were Indiana, Minnesota, North Dakota, and Pennsylvania.

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[59] "CON and Managed Care," *supra* note 41 at 1.

The 1999 telephone survey found that, in addition to the 14 states that had either repealed their certificate of need laws or allowed their certificate of need laws to expire, 11 states had limited certificate of need programs. These states were: Arkansas, Florida, Maryland, Montana, Nebraska, Nevada, New Jersey, Ohio, Oklahoma, Oregon, and Wisconsin.

States With "Full-Service" Certificate of Need Laws

For the purposes of the 1999 survey, states having certificate of need programs covering facilities, such as hospitals, ambulatory surgery centers, and nursing homes, some specialized or tertiary services, and major medical equipment, with one or more expenditure thresholds, were defined as "full-service" certificate of need laws.

Twenty-four states were identified as having "full-service" laws, although their laws, regulations, and program procedures differed widely. These states were: Alabama, Alaska, Connecticut, Delaware, Georgia, Hawaii, Illinois, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, and West Virginia.

Long-Term Care States

By 1999, seven states had certificate of need programs that concentrated only on review of long-term care facilities, beds, or services. These states were: Arkansas, Montana, Nebraska, Ohio, Oklahoma, Oregon, and Wisconsin.

Other Limited Certificate of Need Laws

Four other states had, by 1999, other types of limited certificate of need laws that were difficult to categorize, i.e., Florida, Maryland, Nevada, and New Jersey.

Florida's certificate of need program was amended significantly in 1997. The Florida certificate of need program did not, in 1999, cover equipment purchases and did not have any capital expenditure threshold. The Florida certificate of need program did cover the addition of inpatient hospital and nursing home beds and facilities, new open heart units, and the conversion of acute care beds to skilled nursing facility beds. New burn care units, neonatal special care, organ transplant services, psychiatric services, and substance abuse services were also reviewed.

Maryland is the only state to have, in 1999, both a rate-setting commission and a certificate of need program; in fact, Maryland maintains the only remaining rate-setting commission in the country.

In 1986, Maryland established an exemption for ambulatory surgery centers having no more than four operating rooms, if the facility is used by a single group with a single specialty. In 1995, this exemption was removed and a second exemption was provided for single operating room ambulatory surgery centers, regardless of the number of groups or specialties practicing in the facility.[60] Maryland's Ambulatory Surgery Provider Directory for 1998 included a total of 252 ambulatory surgery providers, including 164 single specialty sites, 38 multi-specialty sites, and 50 hospital sites.[61]

Another amendment to Maryland's certificate of need law in 1995 limited coverage of hospitals to closures and mergers. Public hearings are required on proposed hospital closures and mergers. Maryland does not regulate major medical equipment purchases; however, home health agencies, hospice services, and intermediate care facilities for adolescents are covered.

Nevada's certificate of need program receives approximately two applications per year. Equipment was deregulated in 1995. Currently, the program covers only new construction costing more than $2 million. The program does not cover expenditures that are not directly related to providing health services. Further, the two most populous counties of the 17 counties in Nevada are exempted from certificate of need, i.e., Clark County, which includes Las Vegas and about 60 percent of Nevada's population, and Washoe County, which includes Reno and approximately 15 percent of Nevada's population. Thus, Nevada's certificate of need program has a limited rural focus, covering the 15 sparsely populated rural counties.

New Jersey was, in 1999, in the process of a three-phase reduction in its certificate of need program. On June 30, 1998, the first phase of the process was begun, i.e., additional services in existing facilities were exempted; CT scanners and MRIs were deregulated; and ambulatory surgery centers were receiving minimal reviews. Coverage of various projects was scheduled to expire on March 1, 2000, including ambulatory surgery centers, lithotripsy, obstetrical care, PET scanners, and radiation therapy. The third phase of the deregulation process was to be implemented in 2000, pursuant to the recommendations of a study commission that was charged with determining if the certificate of need program should be continued.[62]

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[60] According to information supplied by the Maryland Health Resources Planning Commission, these exemptions were accomplished through changes in the definition of freestanding ambulatory surgical facility (FASF) and regulatory adjustments in response to the definition.

[61] *Maryland Ambulatory Surgery Provider Directory*, Maryland Health Resources Planning Commission (November 1998).

[62] No additional changes are known to have taken place in 2000.

States Without Certificate of Need Laws

Arizona's certificate of need program was repealed in 1986. The state respondent observed that a nursing home building spree took place immediately after repeal as well as an increase in tertiary and high tech services in hospitals. These service increases appear to have contributed to an increase in rates, according to this respondent. The influx of managed care and the new prospective payment system for Medicare have caused some reductions in services, particularly in emergency services and restorative therapies.

California's certificate of need program was repealed on January 1, 1987, pursuant to a delayed effective bill that was passed in 1985. The state respondent noted that California has not tried to evaluate or reconstruct the effects of the certificate of need repeal; further, he had not observed any effects from the repeal. Hospitals and ambulatory surgery centers were not considered to have problems. Overbuilding in the nursing home industry was noted, however. California requires nonprofit hospitals to report charity care to justify their nonprofit status.

Colorado's certificate of need law was repealed in 1987. Some hospital closings were noted by the respondent and attributed to financial problems. Managed care is pervasive. The respondent had observed tremendous growth of ambulatory surgery centers in Colorado; hospitals were said to be moving in this direction as well. Some hospitals have formed joint ventures with physicians for ambulatory surgery centers. The market in Colorado was said to be receptive to innovative ambulatory care and alternative treatments.

Idaho's certificate of need program was repealed in 1985. The respondent noted that no formal evaluation was conducted of the effects of certificate of need repeal. The new prospective payment system was said to be having dramatic effects on home health services and, perhaps, on hospitals. The impact of the prospective payment system is generating interest in the critical access hospital designation.

Indiana's certificate of need nursing home coverage expired on July 1, 1998. The nursing home industry overbuilt in the 1980s, with low occupancies still a problem, i.e., a few as low as 50 percent in 1999. Forty facilities have closed during the past year. Assisted living facilities, which are not even licensed in Indiana, are increasing rapidly. The assisted living facilities are now required to register. Hospitals have remained stable, i.e., 132 facilities. Larger urban hospitals seem to be buying smaller rural hospitals. Indiana is also seeing the development of hospitals within hospitals, i.e., units for rehabilitation or chronically ill patients.

Kansas' certificate of need program was repealed in 1985. Kansas saw approximately a 10 percent increase in nursing home beds thereafter. Five or six new psychiatric hospitals were built in the 1980s; some of these hospitals are

already out of business. The new prospective payment system was noted as resulting in home health agency closings. In primarily rural Kansas, these home health agency closings are concerning to state officials and the state agency has recently started to track them.

Minnesota's certificate of need program expired on June 30, 1984. Minnesota's certificate of need law was revived in the 1990s for a short period and repealed again in 1995.[63] Moratoriums were placed on both hospitals and nursing homes. The state respondent noted an increase in ambulatory surgery centers, especially recently, and a boom in assisted living facilities. At least two hospitals are converting to critical access hospitals. The moratoriums on hospital and nursing homes have general exceptions, such as health and safety, replacement, and cost neutral additions (no Medicaid impact).

New Mexico's certificate of need program was repealed in 1985. The respondent noted that New Mexico is so very rural that the health care industry in the state is small and not really growing. In some jurisdictions, hospitals are 200 or more miles apart. Managed care was described as having a "strangle hold" on the industry. Almost all of the managed care companies are aligned with a hospital; most doctors are aligned with one of the managed care companies.

North Dakota's certificate of need law was repealed on August 1, 1995. Increases in construction were experienced. Two hospitals have closed. North Dakota's total population is only 630,000, yet health care costs are increasing. The Blue Cross/Blue Shield Company had recently announced a 19 percent increase in premiums for the state employees' benefit plan; last year's increase for the state employees' plan was 12 percent. The increased new construction and the almost total lack of managed care were said to have been factors in these premium increases. North Dakota appears to have anecdotal observations of increases in ambulatory service centers.

Pennsylvania's certificate of need program expired on December 17, 1996. The state respondent had no comment on changes occurring since the expiration.

South Dakota's certificate of need program was repealed in 1988. The respondent noted South Dakota's small population, i.e., approximately 700,000. The respondent said that ambulatory surgery centers in South Dakota were transforming into specialty hospitals. Specialty hospitals were observed by the respondent to be "cherry picking" the paying patients who are in the best health. South Dakota has a small health care industry, only 56 hospitals in 1999, with seven specialty hospitals in urban areas.

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[63] "CON and Managed Care," *supra* note 41 at 1.

Texas's certificate of need program was repealed in 1985. The respondent was reluctant to attribute any changes in the health care industry to the repeal. Texas is growing fast and revising its public health services to accommodate its growing population. The state was said to have a huge long-term care industry. Although no data or general observations were provided by the Texas respondent, he did note the scores of issues being experienced by Texas vis-a-vis the teaching hospitals. A neighboring state's respondent said that Texas's home health industry is suffering, with many closings in the previous months.

Utah's certificate of need program sunsetted in 1985. Utah has a regulatory Medicaid nursing home moratorium because of unbridled growth in the industry. The moratorium only addresses additional facilities. Both psychiatric hospitals and nursing homes have experienced problems because of an influx of services. Nursing home occupancies are down, approximately 76 percent as of October, 1999. Some of the nursing home problems may be attributable to other growth in community and home-based care services. Assisted living facilities were said to have had "huge" growth during the past five years.

Wyoming's certificate of need program was repealed in 1986. Wyoming has a population of only 480,000 people, with one managed care group covering 10,000 people. There is no Medicaid managed care in Wyoming which has only 25 hospitals, two of which are for-profit hospitals. The state respondent stated that all tertiary care goes out of state to Denver or some other large city. Wyoming can't get facilities to come into the state. Between three to 10 of the existing 25 hospitals could be interested in critical access status.

State Moratoriums[64]

As a corollary to the 1999 certificate-of-need telephone survey, a number of state moratoria on services were also identified, as follows: Minnesota, on hospital and nursing home beds; Mississippi, on home health agencies[65]; Missouri, on residential care facilities; Montana, on home health agencies; Nebraska, on hospitals (expired on June 13, 1999); Ohio, on new nursing home beds; Utah, on Medicaid nursing homes[66]; Wisconsin, on nursing home beds; and Wyoming, on long-term care beds. In addition, Georgia reported that the state has not accepted nursing home applications in the last two years; West Virginia reported that the state does not approve personal care services applications, if the service will increase the state budget and that, since personal care services are funded by Medicaid in West Virginia, few, if any are approved.

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[64] Please note that the information provided here on state moratoriums consists of data compiled during the survey; other regulatory or budgetary moratoriums may exist that are not well publicized.

[65] The Mississippi respondent stated that Mississippi had not allowed new home health agencies since 1983.

[66] Utah's Medicaid nursing home bed is regulatory, not statutory, and was reportedly initiated as a result of low occupancy rates and poor quality care.

Summary of Concerns Among States Without Certificate of Need Programs

Among the states without certificate of need programs, the state respondents in five states mentioned excess capacity in nursing home beds, i.e., Arizona, California, Indiana, Kansas, and Utah.

State respondents in five states also mentioned hospital concerns, i.e., Arizona, Minnesota, North Dakota, South Dakota, and Texas (teaching hospital issues).

Rural health issues, such as home health closings, were mentioned by the respondents in seven states, i.e., Idaho, Indiana, Kansas, New Mexico, North Dakota, South Dakota, and Wyoming.

Increases in ambulatory surgery centers were noted by three state respondents, i.e., Minnesota, North Dakota, and South Dakota.

Increases in assisted living facilities were observed by three state respondents, i.e., Indiana, Minnesota, and Utah.

State demographics among the states without certificate of need laws in 1999 were varied. Some of the states without certificate of need programs in 1999 are highly rural and/or sparsely populated (for example, Kansas, New Mexico, North Dakota, South Dakota, and Wyoming) or have intensely urbanized populations (for example, Arizona and Nevada). These states appear to have smaller health care systems than Virginia and many rural health care issues as well as generalized access and availability concerns.

Other states without certificate of need programs have growing populations, with complex health care systems (for example, California and Texas). Some states without certificate of need laws had large managed care penetration (for example, Arizona, California, and Minnesota).

Every state respondent, except one, admitted to health care issues relating to costs or access. No state efforts to monitor or to manage any effects of certificate of need elimination were cited.

VIII. Conclusion

The Special Joint Subcommittee collected substantial data, sought the opinions and suggestions of all parties, and considered many alternative legislative proposals in 1998 and 1999.

The 1998 legislation accomplished significant revisions to COPN by eliminating certification for replacement equipment and requiring registration of equipment purchases. The data collected through the equipment registration process can be used to monitor the trends in Virginia's health care system and could be used to design solutions for unwanted developments.

The Special Joint Subcommittee is convinced that its 1998 changes in the COPN application procedures benefit providers while requiring accountability from the health planning agencies and the Department of Health, without being unduly burdensome.

In the second year of its study, the Special Joint Subcommittee conducted the 50-state telephone survey, monitored the implementation activities of the Department of Health and the health planning agencies, and continued to collected much data, hear considerable testimony, and listen to significant public opinion.

Many alternative legislative proposals were considered in 1999; however, none of these proposals was endorsed by a majority of the Subcommittee. Although no agreement could be reached, there was strong feeling that the certificate of public need process needs streamlining and could be reduced.

Thus, the Special Joint Subcommittee puts forth this study as documentation of its deliberations in the belief that its work will serve as one of the foundations upon which future General Assembly decisions on Virginia's certificate of public need program may be based.

Respectfully submitted,

Senator Jane H. Woods, *Chairman*
Delegate Jay W. DeBoer, *Vice-Chairman*
Delegate Phillip A. Hamilton, *Vice-Chairman*
Senator Emily Couric *
Senator John S. Edwards *
Mr. Howard P. Kern
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Dr. William L. Rich III
Dr. Elizabeth Weick Roycroft
Delegate John H. Rust, Jr.
Mr. J. Knox Singleton
Mr. Douglas C. Suddreth
Dr. H.W. Trieshmann, Jr.

* See Attached Statements

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MEMBERS' STATEMENTS

Senator Emily Couric: One Dissenting Comment

Senator John S. Edwards: Addressing Care for the Indigent and the Uninsured

SENATE OF VIRGINIA

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COMMITTEE ASSIGNMENTS:
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COURTS OF JUSTICE
EDUCATION AND HEALTH
REHABILITATION AND SOCIAL SERVICES

August 25, 2000

TO: **Norma E. Szakal, Senior Attorney**
Senate Education and Health Committee

FROM: **Emily Couric**

RE: **Final draft report from the Special Joint Subcommittee to Study Certificate of Public Need**

I approve the final draft of the Report for publication, with one dissenting comment. I do not concur with the sentence in the concluding section: "Although no agreement could be reached, there was strong feeling that the certificate of public need process needs streamlining and could be reduced."

I would endorse reasonable efforts to make the COPN application process more efficient. However, I will not support attempts to reduce the COPN without careful review of the particular details in any such proposal.

COMMONWEALTH OF VIRGINIA

JOHN S. EDWARDS
[illegible]

SENATE

COMMITTEE ASSIGNMENTS
COMMERCE AND LABOR
COURTS OF JUSTICE
EDUCATION AND HEALTH

September 26, 2000

To: Norma E. Szakal, Senior Attorney

From: John S. Edwards

Re: Final draft report from the Special Joint Subcommittee to Study Certificate of Public Need

As we deregulate the health care industry by limiting the scope of the certificate of public need requirements, the impact on hospitals that deliver the bulk of health care to the indigent and uninsured must be addressed. Medicaid rates cover only $0.79 to the dollar of the cost of health care and Medicare has also curtailed rates paid to hospitals in recent years. Managed care, prospective payment plans, and capitation have further restricted the flow of income to hospitals. Thus, Medicaid and Medicare reimbursements are inadequate to cover the full costs of care and managed care plans and other health insurance programs are not required to contribute to indigent care.

For too long, hospitals have been forced to rely on income from profit centers to cover the costs of indigent care. Now with the lifting of COPN requirements from these profitable services, income to hospitals from these services will likely decline, thereby impacting indigent care services. This can only be corrected by increasing the Medicaid and Medicare reimbursement rates and ensuring that managed care plans and other health insurance products pay their fair share of true costs.

This change also highlights the need to provide ways to cover more of the one million Virginians lacking any health insurance coverage at all. The uninsured are often seen in the emergency rooms of the hospitals, when they receive any care at all, and these costs are absorbed by hospitals. Obviously, if more of these Virginians lacking health insurance were covered by some program that paid the true costs of the care, not only would these patients be better served, but the burden on hospitals to care for the indigent would be lessened.

The health care system is like the sausage that pops out of its skin at one end when squeezed at the other end. The underfunded Medicaid (and Medicare) programs, which have been subsidized by the COPN-covered profit centers of hospitals, must increase their rates of reimbursement as one step toward ensuring that hospitals can continue to provide indigent care. In addition, the Commonwealth's share of the Indigent Health Care Trust Fund should be increased to assist in covering indigent care costs.

As the COPN requirements are phased out, the focus must shift to address more directly the funding of indigent care. Abolishing COPN requirements cannot succeed without also addressing directly the indigent care need, if the Commonwealth is to meet its responsibility to those Virginians who live in the shadows of life.

APPENDIX A

TEXT OF AUTHORIZING RULES
1998 STUDY

Rules of the Senate
General Assembly of Virginia
Amended January 15, 1998
Amended January 22, 1998
1998 Journal of the Senate of Virginia, Volume 1, page 262

20 (h). The Chair of any Committee may appoint subcommittees to consider a particular bill or resolution or to consider matters relative to a portion of the work of the Committee. Such subcommittees shall make recommendations to the Committee. The Chair of the full Committee shall be an ex officio member of all subcommittees. All subcommittees shall be governed by the Rules of the Senate.

20 (i) Any Committee of the Senate may, at its discretion, confer with any Committee of the House of Delegates having under consideration the same subject and arrange joint meetings, hearings or studies, as the Committees deem appropriate.

Rules of the House of Delegates
General Assembly of Virginia
Adopted January 15, 1998

18. The several standing committees shall consider and report on matters specially referred to them and whenever practicable, suggest such legislation as may be germane to the duties of the Committee. It shall be the duty of each committee to inquire into the condition and administration of the laws relating to the subjects which it has in its charge; to investigate the conduct and look to the responsibility of all public officers and agents concerned; and to suggest such measures as will correct abuses, protect the public interests, and promote the public welfare.

Any committee of the house may, at its discretion, confer with a committee of the Senate having under consideration the same subject. No select committee shall be appointed to consider any subject falling properly within the province of a standing committee.

Committees shall in all cases report by bill or resolution, with or without amendment or amendments, in such form that, if passed or agreed to, it will carry into effect their recommendations; but no papers returned therewith shall be printed unless the committee shall so recommend. Every bill shall be printed, as provided in Rule 37. Bills may be considered in executive session, but final vote thereon shall be in open session. No member shall be excluded from any meeting of a committee or subcommittee except as hereinafter provided for the maintenance of

order. The chairman of the Committee shall maintain order, and the business of the committee shall be conducted with decorum at all times in accordance with the Rules of the House.

A recorded vote of members upon each measure shall be taken and the name and number of those voting for, against, or abstaining shall be reported with the bill or resolution and ordered printed on the Calendar.

22. Any bill or resolution introduced in an even-numbered year, and not reported to the House of Delegates by the committee to which it has been referred, may be continued on the agenda of the committee for hearings and committee action during the interim between regular sessions and not otherwise. The committee shall report, prior to the adjournment sine die of the House of Delegates, such bills or resolutions as shall be continued and the Clerk of the House of Delegates shall enter upon the Journal the fact that such bill or resolution has been continued. Any bill or resolution that has been continued and subsequently reported from a committee shall be placed upon the Calendar of the House of Delegates.

The House of Delegates, upon consideration of any bill or resolution on the Calendar may rerefer the bill to the committee reporting the same, and direct the committee to continue the bill or resolution until the following odd-numbered year regular session, and hold such hearings and render such further consideration of the bill or resolution as the committee may deem proper.

The chairman of the committee, or the majority of the membership of the committee, may call meetings of the committee during the interim between sessions, to study, call hearings, and consider any continued bill or resolution, or to consider such other matters as may be germane to the duties of the committee.

(The provision of this rule relating to legislative continuity between sessions shall be subject to the provisions of Article IV, Section 7 of the Constitution of Virginia.)

APPENDIX B

ARTICLE 1.1 (§ 32.1-102.1 ET SEQ.) OF CHAPTER 4 OF TITLE 32.1 CODE OF VIRGINIA MEDICAL CARE FACILITIES CERTIFICATE OF PUBLIC NEED 2000

Chapter 4.
Health Care Planning.

Article 1.

Medical Care Facilities Certificate of Public Need.

32.1-93 through 32.1-102. [Repealed.]

Article 1.1.

Medical Care Facilities Certificate of Public Need.

32.1-102.1. Definitions.
32.1-102.1:1. Equipment registration required.
32.1-102.2. Regulations.
32.1-102.3. Certificate required; criteria for determining need.
32.1-102.3:1. Application for certificate not required of certain nursing facilities or nursing homes.
32.1-102.3:2. Certificates of public need; applications for increases in nursing home bed supplies to be filed in response to Requests For Applications (RFAs).
32.1-102.3:2.1. [Repealed.]
32.1-102.3:2.2. [Expired.]
32.1-102.3:3, 32.1-102.3:4. [Repealed.]
32.1-102.4. Conditions of certificates; monitoring; revocation of certificates.
32.1-102.5. Certificate not transferable.
32.1-102.6. Administrative procedures.
32.1-102.7. [Repealed.]
32.1-102.8. Enjoining project undertaken without certificate.
32.1-102.9. Designation of judge.
32.1-102.10. Commencing project without certificate grounds for refusing to issue license.
32.1-102.11. Application of article.
32.1-102.12. Report required.
32.1-102.13. Transition to elimination of medical care facilities certificate of public need.

Article 1.1.
Medical Care Facilities Certificate of Public Need.

§ 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. Intermediate care facilities.

5. Extended care facilities.

6. Mental hospitals.

7. Mental retardation facilities.

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

9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic

source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, except for the purpose of nuclear cardiac imaging, or such other specialty services as may be designated by the Board by regulation.

10. Rehabilitation hospitals.

11. 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, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;

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

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

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

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

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

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

(1982, c. 388; 1983, c. 533; 1984, c. 740; 1985, c. 513; 1989, c. 517; 1991, c. 561; 1992, c. 612; 1993, c. 704; 1995, c. 524; 1996, c. 1050; 1997, c. 600; 1998, c. 289; 1999, cc. 899, 920, 922; 2000, cc. 850, 920.)

Cross references. - As to transition plan for eliminating the determination of need requirement, see § 32.1-102.13

Editor's note. - Acts 1999, cc. 899 and 922, cl. 4, provides: "That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999 shall be subject to the provisions of this act as if the applications were filed on October 1, 1999."

Acts 1999, c. 922, cl. 5, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment."

The 1996 amendment, in the definition of "Medical care facility," inserted "or not" following "building or agency, whether" and added subdivision 11, and, in the definition of "Project," substituted "psychiatric" for "psychiatic" near the middle of subdivision 5, in subdivision 7, in the second sentence, substituted "Notwithstanding the provisions of this subdivision" for "Notwithstanding the above," added the clause (i) designation, inserted "If the applicant agrees to such conditions as the Commissioner may establish, in compliance with regulations promulgated by the Board, requiring the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care; and," added clause (ii), and rewrote subdivision 8 which formerly read: "Any capital expenditure of one 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, except capital registered with the Commissioner pursuant to regulations developed by the Board, of less than two million dollars that do not involve the expansion of any space in which patient care services are provided, including, but not limited to, expenditures for nurse call systems, materials handling and management information systems, parking lots and garages, child-care centers, and laundry services."

The 1997 amendment, effective March 20, 1997, substituted "nuclear medicine imaging" for "single photon emission computed tomography (SPECT)" throughout the section and substituted "Notwithstanding" for "Notwithstanding" in the second sentence in subdivision 7 of the definition of "'Project'."

The 1998 amendments. - The 1998 amendment by c. 289, in the paragraph defining "Project," in subdivision 5, inserted "scanning" following "(CT)," in subdivision 7, in the first sentence, inserted "scanning" following "(CT)," and added the language beginning "Replacement or upgrade" and ending "certificate of public need."

The 1999 amendments. - The 1999 amendments by cc. 899 and 922, effective March 29, 1999, are identical, and in the paragraph defining "Project," in subdivision 7, deleted "or replacement" following "The addition" at the beginning of the subdivision, deleted the former second sentence, which read: "Notwithstanding the provisions of this subdivision, the Commissioner shall develop regulations (i) providing for the replacement by a medical care facility of existing medical equipment, which is determined by the Commissioner to be inoperable or otherwise in need of replacement without requiring issuance of a certificate of public need, if the applicant agrees to such conditions as the Commissioner may establish, in compliance with regulations promulgated by the Board, requiring the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care; and (ii) providing for the replacement by a medical care facility of existing medical equipment without the issuance of a certificate of public need if the Commissioner has determined a certificate of public need has been previously issued for replacement of the specific equipment," and substituted "of existing equipment shall not require" for "or upgrade of existing magnetic resonance imaging (MRI) shall not have to obtain" in the present second sentence.

The 1999 amendment by c. 920 in the paragraph defining "Project," inserted "computed tomographic (CT) scanning, magnetic source imaging (MSI), or positron emission tomographic (PET) scanning equipment" near the end of subdivision 7.

The 2000 amendments. - The 2000 amendments by cc. 850 and 920 are identical, and inserted "except for the purpose of nuclear cardiac imaging" near the end of the ninth clause in the paragraph defining "Medical care facility"; added the last sentence in the concluding paragraph under the definition of "Medical care facility"; and inserted "except for the purpose of nuclear cardiac imaging" in the fifth clause in the paragraph defining "Project."

Law review. - For article, "The Changing Focus of Peer Review under Medicare," see 20 U. Rich. L. Rev. 315 (1986).

As to certificates of public need, see 22 U. Rich. L. Rev. 667 (1988).

For survey of administrative procedure in Virginia for 1989, see 23 U. Rich. L. Rev. 431 (1989).

For 1992 survey of health care law in Virginia, see 26 U. Rich. L. Rev. 759 (1992).

Constitutionality. - While commissioner's determination that facility would be a specialized center or clinic developed for the provision of out-patient or ambulatory surgery, thus bringing it within the scope of this section's definition of "medical care facility," might leave room for argument, the determination did not pose an issue of classification that is unconstitutionally vague. Gordon v. Allen, 24 Va. App. 272, 482 S.E.2d 66 (1997) (decided under prior law).

Applied in Fairfax Surgical Ctr., Inc. v. State Health Comm'r, 12 Va. App. 576, 405 S.E.2d 430 (1991).

§ 32.1-102.1:1. Equipment registration required.

Within thirty calendar days of becoming contractually obligated to acquire any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation, any person shall register such purchase with the Commissioner and the appropriate health planning agency.

(1999, cc. 899, 922; 2000, c. 931.)

Effective date. - This section is effective March 29, 1999.

Editor's note. - Acts 1999, cc. 899 and 922, cl. 4, provides: "That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999."

Acts 1999, cc. 899 and 922, cl. 5, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment."

The 2000 amendments. - The 2000 amendment by c. 931 substituted "planning" for "systems".

§ 32.1-102.2. Regulations.

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

1. Shall establish concise procedures for the prompt review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects;

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

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

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

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

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care. In addition, the Board's licensure regulations shall direct the Commissioner to condition the issuing or renewing of any license for any applicant whose certificate was approved upon such condition on whether such applicant has

complied with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

(1982, c. 388; 1991, c. 561; 1993, c. 704; 1996, c. 1050; 1999, c. 926; 1999, cc. 899, 922, 926.)

Editor's note. - Acts 1999, cc. 899 and 922, cl. 4, provides: "That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999."

Acts 1999, cc. 899 and 922, cl. 5, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment."

Acts 1999, c. 926, cl. 2, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of its enactment."

The 1996 amendment substituted "discernible" for "discernable" following "of a competitive market or to have no" in subdivision A 3, in subdivision A 4, inserted "be less than $1,000 nor" following "Such fees shall not" and substituted "$20,000" for "$10,000" following "expenditure for the project or."

The 1999 amendments. - The 1999 amendments by cc. 899 and 922, effective October 1, 1999, are identical, and in subsection A, substituted "concise procedures for the prompt" for "procedures for the" in subdivision 1, and in present subdivision 5, substituted "May establish, on or after July 1, 1999" for "Shall establish" at the beginning of the subdivision, and added the last sentence, in subsection C, substituted "condition the issuing or renewing of" for "consider, when issuing or renewing," and inserted "on" following "such condition."

The 1999 amendment by c. 926, in subsection A, deleted "and" at the end of subdivision 3, added subdivision 4, and redesignated former subdivision 4 as present subdivision 5.

Applied in State Bd. of Health v. Virginia Hosp. Ass'n, 1 Va. App. 5, 332 S.E.2d 793 (1985).

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

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

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

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

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

planning agency.

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

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

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

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

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

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

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

10. The availability of resources for the project.

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

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

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

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

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

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

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

health services by other persons in the area.

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

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

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

(1982, c. 388; 1984, c. 740; 1993, c. 704; 1999, c. 926; 2000, c. 931.)

Editor's note. - Acts 1999, c. 926, cl. 2, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of its enactment."

The 1999 amendment inserted "not relevant to a rural locality's needs" in the fourth sentence of subsection A, and in subsection B, added "including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care" at the end of subdivision 4, added "in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care" at the end of subdivision 6, added "however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered" at the end of subdivision 9, and added "including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care" at the end of subdivision 19.

The 2000 amendments. - The 2000 amendment by c. 931 substituted "planning" for "systems" in subdivisions B 1 and B 2.

"Consistent with," as used in the context of subsection A of this section, does not mean "exactly alike" or "the same in every detail." It means, instead, "in harmony with," "compatible with," "holding to the same principles," or "in general agreement with." Roanoke Mem. Hosps. v. Kenley, 3 Va. App. 599, 352 S.E.2d 525 (1987).

This section limits the authority of the Commissioner with respect to the issuance of a certificate of need. First, a decision to issue or approve the issuance of a certificate must be consistent with the most recent applicable provisions of the State Health Plan. Second, in determining whether such public need for a project has been demonstrated, the Commissioner must consider the 20 criteria set forth in subsection B. Roanoke Mem. Hosps. v. Kenley, 3 Va. App. 599, 352 S.E.2d 525 (1987).

Justification for denial. - While subsection (A) allows Commissioner to grant a Certificate of Public Need (COPN) if there is a need therefor and the Commissioner finds that the State Medical Facilities Plan C (SMFP) is outdated, the Commissioner cannot deny a COPN based on a finding that the existing SMFP is outdated. Sentara Norfolk Gen. Hosp. v. State Health Comm'r, 30 Va. App. 267, 516 S.E.2d 690 (1999).

The State Health Commissioner did not err in failing to make specific findings on all 20 factors which he is required to consider under subsection B of this section; rather, the Commissioner's decision must show that due consideration was given to the evidence bearing upon those factors which were relevant to the application under consideration, and the Commissioner's decision, adopting the findings and conclusions of the hearing officer, complied with this standard. Bio-Medical Applications of Arlington, Inc. v. Kenley, 4 Va. App. 414, 358 S.E.2d 722 (1987).

Certificate of need. - Under Virginia's Health Care Planning law, before certain projects may be commenced, a medical care facility shall first obtain a certificate of need (CON) issued by the commissioner. The commissioner must determine that a public need for the project has been

demonstrated and any decision to issue a CON must be consistent with the most recent applicable provisions of the State Health Plan (SHP) and the State Medical Facilities Plan (SMFP). If the commissioner finds that the provisions of either plan are inaccurate, outdated, inadequate, or otherwise inapplicable, the commissioner may nevertheless issue a CON and institute procedures to amend the plan appropriately. Johnston-Willis, Ltd. v. Kenley, 6 Va. App. 231, 369 S.E.2d 1 (1988).

Review of commissioner's decisions. - The commissioner's decision on whether the State Health Plan or State Medical Facilities Plan is inaccurate, outdated, inadequate or otherwise inapplicable, is a decision within the specialized competence of the commissioner and is entitled to special weight in the courts. For that reason judicial interference is permissible only for relief against the arbitrary and capricious action that constitutes a clear abuse of the delegated discretion. Johnston-Willis, Ltd. v. Kenley, 6 Va. App. 231, 369 S.E.2d 1 (1988).

Commissioner's adoption of seventy-five percent minimum occupancy standard under State Health Plan not arbitrary and capricious, since the national guidelines are, at a minimum, suggestive, and the commissioner may properly consider the guidelines when exercising discretion given to him by the General Assembly. Johnston-Willis, Ltd. v. Kenley, 6 Va. App. 231, 369 S.E.2d 1 (1988).

Applied in State Bd. of Health v. Virginia Hosp. Ass'n, 1 Va. App. 5, 332 S.E.2d 793 (1985).

§ 32.1-102.3:1. Application for certificate not required of certain nursing facilities or nursing homes.

An application for a certificate that there exists a public need for a proposed project shall not be required for nursing facilities or nursing homes affiliated with facilities which, on January 1, 1982, and thereafter, meet all of the following criteria:

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

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

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

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

b. Admissions to the assisted living facility unit are restricted to individuals defined as ambulatory by the Department of Social Services;

c. Admissions to the nursing facility or nursing home unit are restricted to those individuals who are residents of the assisted living facility unit.

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

(1982, c. 659; 1993, cc. 957, 993.)

The number of this section was assigned by the Virginia Code Commission, the number in the 1982 act having been 32.1-96.1.

Editor's note. - Acts 1993, cc. 957 and 993, which amended this section, provide in cl. 4: "That the provisions of this act shall be implemented to the extent funds are appropriated therefor." See Acts 1993, c. 994, item 381 B, which relates to the extent funds have been appropriated for Acts 1993, cc. 957 and 993.

The 1993 amendments. - The 1993 amendments by cc. 957 and 993 are identical, and in subdivision 2, inserted "facility or nursing" and substituted "an adult care residence" for "a home for adults"; in subdivision 3 b, substituted "adult care residence" for "home for adults"; in subdivision 3 c, inserted "facility or nursing" and substituted "adult care residence" for "home for adults." See the Editor's note.

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

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

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

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

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

number of beds that are not nursing home beds or sixty beds, (iii) the number of new nursing home beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed twenty percent of its total number of beds that are not nursing home beds, and (iv) the continuing care retirement community has established a qualified resident assistance policy.

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

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

G. For the purposes of this section:

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

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

"Qualified resident assistance policy" means a procedure, consistently followed by a facility, pursuant to which the facility endeavors to avoid requiring a resident to leave the facility because of inability to pay regular charges and which complies with the requirements of the Internal

Revenue Service for maintenance of status as a tax exempt charitable organization under § 501 (c) (3) of the Internal Revenue Code. This policy shall be (i) generally made known to residents through the resident contract and (ii) supported by reasonable and consistent efforts to promote the availability of funds, either through a special fund, separate foundation or access to other available funds, to assist residents who are unable to pay regular charges in whole or in part.

This policy may (i) take into account the sound financial management of the facility, including existing reserves, and the reasonable requirements of lenders and (ii) include requirements that residents seeking such assistance provide all requested financial information and abide by reasonable conditions, including seeking to qualify for other assistance and restrictions on the transfer of assets to third parties.

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

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

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

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

(1989, c. 517; 1990, cc. 191, 478, 753, 845; 1991, c. 561; 1992, cc. 612, 682; 1993, cc. 347, 474, 540, 564, 704, 762, 957, 993; 1994, cc. 57, 680, 711, 726, 797; 1995, cc. 505, 632, 641, 695, 753; 1996, cc. 531, 849, 901; 1998, c. 794.)

Editor's note. - Acts 1992, c. 612, cl. 3, as amended by Acts 1993, c. 704, cl. 2, provides that the Secretary of Health and Human Resources shall study the utility and feasability of establishing, for use in the medical care facilities certificate of public need program on a statewide or regional basis, limits on total medical care facilities capital spending which can be authorized by the Commissioner of Health. The study shall include, but need not be limited to, the historic pattern of medical care facilities capital spending in Virginia, mechanisms for determining an adequate capital spending budget for the state and for individual health planning regions, methods for prioritizing capital spending needs, and the feasibility of implementing regional demonstrations of the use of capital spending limits in the administration of the certificate of public need program. The study shall address the impact of capital spending limits on (i) efforts to reorganize the delivery of health care through the creation of community care networks of hospitals, physicians, and other health care providers and (ii) the closure of hospitals and efforts to assist hospitals at risk of closure to make a transition to the provision of needed medical care services. The study shall also address the use of reimbursement policy to discourage development of excess medical care facilities and services. The Secretary shall report the findings of this study to the Governor, the Joint Commission on Health Care, and the General Assembly by October 1, 1993.

Acts 1993, c. 564, cl. 2 provides: "That the State Health Commissioner is authorized to (1) to accept applications for projects excepted from the moratorim fifteen days after adjournment sine die of the Session at which the exception is enacted, and (2) to approve any such application on or after July 1 following such adjournment."

Acts 1993, cc. 957 and 993, which amended this section, in cl. 3 provide: "That the Secretary of Health and Human Resources shall study and analyze the intensity of service needs in Virginia's adult

care residence [assisted living facility] population and shall report his findings to the Joint Commission on Health by October 1, 1994."

Acts 1993, cc. 957 and 993, which amended this section, provide in cl. 4: "That the provisions of this act shall be implemented to the extent funds are appropriated therefor." See Acts 1993, c. 994, item 381 B, which relates to the extent funds have been appropriated for Acts 1993, cc. 957 and 993.

Acts 1994, cc. 57 and 680, cl. 2, provide that "at any time on or after the effective date of this provision, the Commissioner shall accept, shall expeditiously review, and may approve an application for a project complying with subdivision 9 of § 32.1-102.3:2."

Acts 1996, c. 531, cl. 1, amended this section effective April 2, 1996, until July 1, 1996. Acts 1996, c. 849, cl. 1, amended this section, effective July 1, 1996, until July 2, 1996. For the details on the changes to the section by these acts and their subsequent expiration, see the notes below.

Acts 1996, c. 531, cl. 3, provides: "[t]hat, except for this enactment clause, this act shall expire on July 1, 1996, unless the moratorium provided in § 32.1-102.3:2 remains in effect on July 1, 1996; the Commissioner, however, shall continue to review and may approve any applications accepted for review prior to July 1, 1996, pursuant to the exceptions included in § 32.1-102.3:2, as it was in effect on the date this act becomes effective. The Commissioner shall take final action on all such applications by December 31, 1996." The moratorium did not remain in effect on July 1, 1996, having been eliminated by Acts 1996, c. 901. Therefore, the amendment by c. 531 expired on July 1, 1996.

Acts 1996, c. 849, cl. 2, provides: "That, except for this enactment clause, this act shall expire on July 2, 1996, unless the moratorium provided in § 32.1-102.3:2 remains in effect. The Commissioner, however, shall continue to review and may approve any applications accepted for review through July 1, 1996, pursuant to the exceptions included in § 32.1-102.3:2, as it was in effect on the date this act becomes effective. The Commissioner shall take final action on all such applications by December 31, 1996." The moratorium did not remain in effect, having been eliminated by Acts 1996, c. 901. Therefore, the amendment by c. 849 expired on July 2, 1996.

Acts 1996, c. 901, cl. 2, provides: "[t]hat the Commissioner of Health, in cooperation with the Director of the Department of Medical Assistance Services and other affected public and private stakeholders, shall evaluate the need for and appropriateness of requiring adult care residences [assisted living facilities] providing assisted living and intensive assisted living levels of care to be subject to the Commonwealth's Certificate of Public Need regulations and the requirements established pursuant to this article or a similar and parallel program for determining need and preventing redundant capitalization. The Commissioner shall provide to the Secretary of Health and Human Resources and the Joint Commission on Health Care an interim report by October 1, 1996, and a final report of his findings and recommendations by June 1, 1997."

Acts 1996, c. 901, cl. 3, provides: "[t]hat the Joint Commission on Health Care shall study the appropriateness of the Commonwealth's Certificate of Public Need regulations and requirements, including, but not limited to, the need for and appropriateness of requiring outpatient or ambulatory surgical centers to be subject to the Commonwealth's Certificate of Public Need regulations and requirements pursuant to this act. The Department of Health and the health-system agencies shall provide staff support and technical assistance for the study. The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the 1997 Session of the General Assembly."

Acts 1998, c. 794, cl. 3 provides: "That any continuing care retirement community with a certificate of public need issued on August 1, 1997, shall be eligible for a one-time, eighteen-month open admission period for sixty beds."

Acts 1999, c. 912, cl. 1, provides: "§ 1. Certain medical care facilities certificate of public need.

"Notwithstanding the provisions of § 32.1-102.3:2, or any standards promulgated by the Board of Health as regulations pursuant thereto, for the approval and issuance by the Commissioner of Requests for Proposals, the Commissioner (i) shall approve and issue a Request for Application for an increase in the nursing home bed supply for any planning district which would have met the requirements for determining need in compliance with the Board's regulations but for an increase in nursing home bed

supply which was authorized by the Commissioner pursuant to the provisions of § 32.1-102.3:2, as such law existed prior to the effective date of Chapter 901 of the 1996 Acts of Assembly, when such beds have not yet been licensed and (ii) may approve, authorize and accept applications for any certificate of public need for any project which would result in an increase in the number of nursing home or nursing facility beds in such planning district."

Acts 2000, c. 859 provides: "§ 1. Certain certificate of public need authorized.

"A. Notwithstanding the provisions of subdivision 10 of § 32.1-102.3:2 as in effect on June 30, 1996, the Commissioner of Health may accept and approve a request to amend the conditions of a certificate of public need issued for an increase in beds in which nursing facility or extended care services are provided to allow such facility to continue, until June 30, 2003, to admit persons, other than residents of the cooperative units, to its nursing facility beds when such facility (i) is operated by an association described in § 55-458, (ii) was created in connection with a real estate cooperative, (iii) offers its residents a level of nursing services consistent with the definition of continuing care in Chapter 49 (§ 38.2-4900) of Title 38.2, and (iv) was issued a certificate of public need prior to October 3, 1995.

"B. Further, notwithstanding the provisions of § 32.1-102.3:2, as currently in effect, or the provisions of any Request For Applications (RFAs) issued by the Commissioner of Health pursuant to § 32.1-102.3:2 designating any planning district as authorized to respond to any RFA, the Commissioner of Health shall authorize and accept an application and may issue a certificate of public need for an increase of sixty beds in which nursing facility or extended care services are to be provided when (i) such application is filed by an existing sixty-bed facility located in Giles County within Planning District 4, (ii) such existing nursing facility currently has a high occupancy rate, (iii) such existing nursing facility is located in a highly rural jurisdiction with mountainous terrain, and (iv) the new nursing facility beds are to be dedicated to the provisions of skilled nursing, hospice services and care of persons with Alzheimer's and related diseases."

Acts 2000, c. 868 provides: "§ 1. Amendment of certain certificate of public need authorized.

"Notwithstanding the provisions of subdivision 10 of § 32.1-102.3:2 as in effect on June 30, 1996, the Commissioner of Health may accept and approve a request to amend the conditions of a certificate of public need issued for an increase in beds in which nursing facility or extended care services are provided to allow such facility to continue to admit persons, other than residents of the cooperative units, to its nursing facility beds for three years from the date of issuance of a certificate of occupancy for the second mid-rise residential unit building associated with such facility or June 30, 2003, whichever is the first to occur, when such facility (i) is operated by an association described in § 55-458; (ii) was created in connection with a real estate cooperative; (iii) offers its residents a level of nursing services consistent with the definition of continuing care in Chapter 49 (§ 38.2-4900) of Title 38.2; and (iv) was issued a certificate of public need prior to October 3, 1995."

Acts 2000, c. 912 provides: "§ 1. Amendment of certain certificate of public need authorized.

"Notwithstanding the provisions of subdivision 6 of § 32.1-102.3:2 as in effect on June 30, 1996, the Commissioner of Health may accept and approve a request to amend the conditions of a certificate of public need issued to a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 for an increase in beds in which nursing facility or extended care services are provided to allow such continuing care provider to continue, until the continuing care contract holders constitute ninety percent of the occupancy for such facility or July 1, 2004, whichever is the first to occur, to admit patients, other than continuing care contract holders, with whom the facility has an agreement with the individual responsible for the patient for private payment of the costs upon the following conditions being met: (i) the continuing care community is established for the care of retired military personnel and their families and (ii) the facility's bond requires that the nursing home unit maintain a ninety percent occupancy rate."

The 1993 amendments. - The 1993 amendments by cc. 957 and 993 are identical, and substituted "nursing facility" for "nursing home" throughout this section, substituted "an adult care residence" for "a home for adults facility" throughout this section, and substituted "adult care residence" for "home for adults facility" throughout this section. See the Editor's note.

The 1996 amendments. - The 1996 amendment by c. 531, effective April 2, 1996, substituted "acknowledgment" for "acknowledgement" in two places and rewrote subdivision 18, which formerly read:

"The issuance of a certificate of public need to a nonprofit nursing facility project located in Henrico County that is designed to provide a continuum of care for patients with Alzheimer's Disease and related disorders if (i) the project was under construction January 1, 1995, and will be ready for occupancy no later than June 1, 1996; (ii) not less than thirty of the newly constructed beds will be designated and retained as private-pay beds; and (iii) the total number of beds to be constructed does not exceed sixty beds." For expiration date, see the Editor's note detailing Acts 1996, c. 531, cl. 3.

The 1996 amendment by c. 849 added subdivisions 19 and 20. For expiration date, see the Editor's note detailing Acts 1996, c. 849, cl. 2.

The 1996 amendment by c. 901 rewrote this section.

The 1998 amendments. - The 1998 amendment by c. 794, in subsection A, inserted "which comply with the requirements established in this section," and inserted "in a planning district"; in subsection C, in the last sentence, substituted "may" for "shall" following "the Board," and added subsections D through I.

Law review. - For survey of administrative procedure in Virginia for 1989, see 23 U. Rich. L. Rev. 431 (1989).

§ 32.1-102.3:2.1.

Repealed by Acts 1998, c. 794.

§ 32.1-102.3:2.2.

Editor's note. - This section was enacted by Acts 1997, c. 568, effective March 20, 1997, and expired July 1, 1998, pursuant to the terms of Acts 1997, c. 568, cl. 3.

§§ 32.1-102.3:3, 32.1-102.3:4.

Repealed by Acts 1992, c. 612.

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

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

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

C. A certificate may be revoked when:

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

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

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

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

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

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

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

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

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

(1982, c. 388; 1991, c. 561; 1992, c. 682; 1993, cc. 668, 704; 1998, c. 794.)

The 1998 amendments. - The 1998 amendment by c. 794, in subsection B, added the second and last sentences; in subsection C, added subdivision 4; deleted former subsection D relating to the authority of the Commissioner to grant extensions for completion of nursing home bed projects; redesignated former subsections E through H as present subsections D through G; in present subsection E, inserted "up to" preceding "$100"; and in present subsection F, in the second paragraph, inserted "up to" preceding "$100."

§ 32.1-102.5. Certificate not transferable.

No certificate issued for a project shall be transferable.

(1982, c. 388.)

§ 32.1-102.6. Administrative procedures.

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

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

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

B. The appropriate health planning agency shall review each completed application for a certificate within sixty calendar days of the day which begins the appropriate batch review cycle as established by the Board by regulation pursuant to subdivision A 1 of § 32.1-102.2, such cycle not to exceed 190 days in duration. The health planning agency shall hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. The health planning agency shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where a project is proposed to be located at least nine calendar days prior to the public hearing. In no case shall a health planning agency hold more than two meetings on any application, one of which shall be the public hearing conducted by the board of the health planning agency or a subcommittee of the board. The applicant shall be given the opportunity, prior to the vote by the board of the health planning agency or a committee of the agency, if acting for the board, on its recommendation, to respond to any comments made about the project by the health planning agency staff, any information in a staff report, or comments by those voting; however, such opportunity shall not increase the sixty-calendar-day period designated herein for the health planning agency's review unless the applicant or applicants request a specific extension of the health planning agency's review period.

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

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

C. After commencement of any public hearing and before a decision is made there shall be no ex parte contacts concerning the subject certificate or its application between (i) any person

acting on behalf of the applicant or holder of a certificate or any person opposed to the issuance or in favor of revocation of a certificate of public need and (ii) any person in the Department who has authority to make a determination respecting the issuance or revocation of a certificate of public need, unless the Department has provided advance notice to all parties referred to in (i) of the time and place of such proposed contact.

D. The Department shall commence the review of each completed application upon the day which begins the appropriate batch review cycle and simultaneously with the review conducted by the health planning agency.

A determination whether a public need exists for a project shall be made by the Commissioner within 190 calendar days of the day which begins the appropriate batch cycle.

The 190-calendar-day review period shall begin on the date upon which the application is determined to be complete within the batching process specified in subdivision A 1 of § 32.1-102.2.

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

The Commissioner shall make determinations in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.) except for those parts of the determination process for which timelines and specifications are delineated in subsection E of this section. Further, the parties to the case shall include only the applicant, any person showing good cause, any third-party payor providing health care insurance or prepaid coverage to five percent or more of the patients in the applicant's service area, or the health planning agency if its recommendation was to deny the application.

E. Upon entry of each completed application or applications into the appropriate batch review cycle:

1. The Department shall establish, for every application, a date between the eightieth and ninetieth calendar days within the 190-calendar-day review period for holding an informal fact-finding conference, if such conference is necessary.

2. The Department shall review every application at or before the seventy-fifth calendar day within the 190-calendar-day review period to determine whether an informal fact-finding conference is necessary.

3. Any person seeking to be made a party to the case for good cause shall notify the Department of his request and the basis therefor on or before the eightieth calendar day following the day which begins the appropriate batch review cycle.

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

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

6. The provisions of subsection D of § 9-6.14:11 notwithstanding, if a determination whether a public need exists for a project is not made by the Commissioner within forty-five calendar

days of the closing of the record, the Commissioner shall notify the applicant or applicants and any persons seeking to show good cause, in writing, that the application or the application of each shall be deemed approved twenty-five calendar days after expiration of such forty-five-calendar-day period, unless the receipt of recommendations from the person performing the hearing officer functions permits the Commissioner to issue his case decision within that twenty-five-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise impact the effectiveness of subdivision E 6 of § 32.1-102.6.

7. In any case when a determination whether a public need exists for a project is not made by the Commissioner within seventy calendar days after the closing of the record, the application shall be deemed to be approved and the certificate shall be granted.

8. If a determination whether a public need exists for a project is not made by the Commissioner within forty-five calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications issued pursuant to § 32.1-102.3:2 may, prior to the application being deemed approved, petition for immediate injunctive relief pursuant to § 9-6.14:21, naming as respondents the Commissioner and all parties to the case. During the pendency of the proceeding, no applications shall be deemed to be approved. In such a proceeding, the provisions of § 9-6.14:21 shall apply.

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

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

In any appeal of the Commissioner's case decision granting a certificate of public need pursuant to a Request for Applications issued pursuant to § 32.1-102.3:2, the court may require the appellant to file a bond pursuant to § 8.01-676.1, in such sum as shall be fixed by the court for protection of all parties interested in the case decision, conditioned on the payment of all damages and costs incurred in consequence of such appeal.

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

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

I. The applicants, and only the applicants, shall have the authority to extend any of the time periods specified in this section. If all applicants consent to extending any time period in this section, the Commissioner, with the concurrence of the applicants, shall establish a new schedule

for the remaining time periods.

(1982, c. 388; 1984, c. 740; 1991, c. 561; 1999, cc. 899, 922; 2000, c. 931.)

Editor's note. - Acts 1999, cc. 899 and 922, cl. 4, provides: "That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999."

Acts 1999, cc. 899 and 922, cl. 5, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment."

The 1999 amendments. - The 1999 amendments by cc. 899 and 922, effective October 1, 1999, are identical, and in subsection A, added the last sentence of the first paragraph and added the present second paragraph, inserted "calendar" near the beginning of the third paragraph, and in subsection B, in the first sentence, substituted "review each completed" for "begin to review each complete" and substituted "sixty calendar days of the day which begins the 120-calendar-day review period" for "such time as the Board may prescribe by regulation," inserted "calendar" following "least nine" in the third sentence, substituted "the public" for "a public" in the fourth sentence, and in the fifth sentence, inserted "by the board of the health systems agency or a committee of the agency, if acting for the board, on its recommendation," and inserted "however, such opportunity shall not increase the sixty-calendar-day period designated herein for the health systems agency's review unless the applicant requests a specific extension in the health systems agency's review period," substituted "ten calendar days after the completion of its sixty-calendar-day review or such other period in accordance with the applicant's request for extension" for "such time as may be prescribed by the Board by regulation" in the second paragraph of subsection B, added the third paragraph of subsection B; substituted "any public" for "a public" in subsection C; added the present first, third and fourth paragraphs of subsection D, inserted "calendar" in the second paragraph of subsection D, in the fifth paragraph, deleted "Such determination shall be made in accordance with" at the beginning of the paragraph, and substituted "shall only apply to those parts of the determination process for which timelines and specifications are not delineated in subsection E of this section. Further" for "except that"; added subsections E and F; added the subsection G designator and substituted "section" for "subsection" in said subsection; redesignated former subsection E as present subsection H, and added subsection I.

The 2000 amendments. - The 2000 amendment by c. 931 rewrote the section.

Regulations allowing more than 120 days for case decision are invalid. - By expressly eliminating any reference to "initial determination" in subsection E as it existed prior to the 1984 amendment and by placing the Commissioner's determination under the provision of the Administrative Process Act, the General Assembly manifested its intent to simplify the review process and to place a 120-day limit on the time within which the case decision, i.e., the determination, could be made. Regulations adopted by the Board, to the extent that they allow a longer period of time, are invalid. State Bd. of Health v. Virginia Hosp. Ass'n, 1 Va. App. 5, 332 S.E.2d 793 (1985) (decided prior to 2000 amendments).

§ 32.1-102.7.

Repealed by Acts 1984, c. 740.

§ 32.1-102.8. Enjoining project undertaken without certificate.

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

the provision of services through the project.

(1982, c. 388.)

Law review. - For survey on evidence in Virginia for 1989, see 23 U. Rich. L. Rev. 647 (1989).

§ 32.1-102.9. Designation of judge.

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

(1982, c. 388; 1984, c. 740.)

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

Commencing any project without a certificate required by this article shall constitute grounds for refusing to issue a license for such project.

(1982, c. 388.)

§ 32.1-102.11. Application of article.

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

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

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

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

C. For the purposes of this section:

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

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

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

"Purchased" means that the equipment has been acquired by the owner or operator of an existing medical care facility or the developer of a proposed medical care facility, or the owner or operator of the facility or the developer can present evidence of a legal obligation to acquire the equipment in the form of an executed contract or appropriately signed order or requisition and

payment has been made in full by June 30, 1992.

(1982, c. 388; 1986, c. 615; 1992, c. 612.)

§ 32.1-102.12. Report required.

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

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

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

3. An analysis of the appropriateness of continuing the certificate of public need program for at least three project categories in accordance with the five-year schedule for analysis of all project categories;

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

5. An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

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

7. 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.

(1997, c. 462; 1999, cc. 899, 922.)

Editor's note. - Acts 1999, cc. 899 and 922, cl. 4, provides: "That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999."

Acts 1999, cc. 899 and 922, cl. 5, effective October 1, 1999, provides: "That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment."

The 1999 amendments. - The 1999 amendments by cc. 899 and 922, effective October 1, 1999, are identical, and added subdivision 4, redesignated former subdivisions 4, 5, and 6 as present subdivisions 5, 6, and 7, respectively, deleted "and" at the end of subdivision 6, added "and" at the end of subdivision 7, and added subdivision 8.

§ 32.1-102.13. Transition to elimination of medical care facilities certificate of public need.

A. **Transition required.**A transition for elimination of the requirements for determination of need pursuant to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of this title shall begin on July 1, 2001, and shall be completed by July 1, 2004, as determined by the General Assembly.

B. **Plan to be developed.**The deregulation required by this section shall be accomplished in accordance with a plan to be developed by the Joint Commission on Health Care. The Joint Commission on Health Care shall work collaboratively with the Departments of Health, Medical Assistance Services, and Health Professions in conjunction with the implementation of the provisions of this section. The Departments of Health, Medical Assistance Services, and Health Professions shall provide technical assistance to the Joint Commission. All agencies of the Commonwealth shall provide assistance to the Joint Commission, upon request. The Joint Commission shall seek input from all classes of health care consumers, providers, and representatives of health care facilities in the performance of the duties of the Joint Commission hereunder. The plan shall include recommendations for legislative and administrative consideration to carry out, in accordance with subsection A of this section, the elimination of the requirements for determination of need. Such plan shall be submitted to the chairmen of the House Appropriations, Senate Finance, House Health, Welfare and Institutions, and Senate Education and Health Committees on or before December 1, 2000, for review and approval by the 2001 Session of the General Assembly.

C. **Components of the plan.**The plan for deregulation to be developed by the Joint Commission on Health Care shall include, but need not be limited to, provisions for (i) meeting the health care needs of the indigent citizens of the Commonwealth, including access to care and provision for all health care providers to share in meeting such needs; (ii) meeting the health care needs of the uninsured citizens of the Commonwealth, including access to care; (iii) establishing licensure standards for the various deregulated services, including whether nationally recognized accreditation standards may be adopted, to protect the public health and safety and to promote the quality of services provided by deregulated medical facilities and projects; (iv) providing adequate oversight of the various deregulated services to protect the public health and safety; (v) providing for monitoring the effects of deregulation during the transition period and after full implementation of this section on the number and location of medical facilities and projects throughout the Commonwealth; (vi) determining the effect of deregulation of long-term care facilities and new hospitals with respect to the requirements for determination of need; (vii) determining the effect of deregulation on the unique mission of academic medical centers; (viii) determining the effect of deregulation on rural hospitals which are critical access hospitals; (ix) recommending a schedule for necessary statutory changes to implement the plan and for requiring, subject to approval of the General Assembly, that the appropriate regulatory boards promulgate regulations implementing the Commission's plan prior to any deregulation recommended in the plan.

D. **Fiscal impact.**In developing the plan, the Commission shall also consider the impact of deregulation on state-funded health care financing programs and shall include an examination of

the fiscal impact of such deregulation on the market rates paid by such financing programs for health care and long-term care services.

(2000, c. 894.)

APPENDIX C

STUDY AGENDAS
PUBLIC HEARING ANNOUNCEMENT
AND
CALL FOR PROPOSALS

1998 INTERIM

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE OF THE SENATE COMMITTEE ON EDUCATION AND HEALTH AND THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS TO STUDY CERTIFICATE OF PUBLIC NEED

established pursuant to

The Rules of the Senate, Rule 20 (f) and Rule 21 (f)

and

The Rules of the House of Delegates, Rule 8 and Rule 8-2

[illegible]

Senate Room B, General Assembly Building

Richmond, Virginia [illegible]

I. Call to Order, Senator Jane H. Woods, Chairman, Senate Committee on Education and Health

II. Introduction of Members,,Chairman

III. Authority for the Study and Opening Remarks,,Chairman

IV. A Brief History of the Certificate of Public Need Program in Virginia,,
Norma E. Szakal, Senior Attorney, Education and Health
Division of Legislative Services

V. Statistical and Procedural Review,,
Paul E. Parker, Director, The Certificate of Public Need Program
Virginia Department of Health

VI. The Role of the Regional Health Systems Agencies,,
Dean Montgomery, President, Regional Health Systems Association and Executive Director, Health Systems Agency of Northern Virginia

VII. Other Comments (at the discretion of the Joint Subcommittee)

VIII. Proposed Study Objectives, Schedule, and Plan,,
Norma E. Szakal, Senior Attorney, Education and Health
Division of Legislative Services

IX. Discussion and Direction to Staff,,Joint Subcommittee

X. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman, Senate Committee on Education and Health*
Delegate Jay W. DeBoer, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Delegate Phillip A. Hamilton, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Senator Emily Couric
Senator John S. Edwards
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Delegate John H. Rust, Jr.

Staff:

Norma E. Szakal, *Senior Attorney, Education and Health, Division of Legislative Services*
Brenda H. Edwards, *Senior Research Associate, Education and Health, Division of Legislative Services*
Brian B. Taylor, *Senate Committee Operations*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE OF
THE SENATE COMMITTEE ON EDUCATION AND HEALTH
AND
THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS
TO STUDY CERTIFICATE OF PUBLIC NEED
established pursuant to
The Rules of the Senate (Rule 20 (h) and Rule 20 (i))
and
The Rules of the House of Delegates (Rule 18 and Rule 22)
August 25, 1998, 6:30 p.m.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman, Senate Committee on Education and Health

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Public Hearing

Registered Speakers (see attached list)

V. Discussion—Joint Subcommittee

VI. Direction to Staff—Joint Subcommittee

VII. Adjournment

MEMBERS:
Senator Jane H. Woods, *Chairman, Senate Committee on Education and Health*
Delegate Jay W. DeBoer, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Delegate Phillip A. Hamilton, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Senator Emily Couric
Senator John S. Edwards
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Delegate John H. Rust, Jr.

Staff:
Norma E. Szakal, *Senior Attorney, Education and Health, Division of Legislative Services*
Brenda H. Edwards, *Senior Research Associate, Education and Health, Division of Legislative Services*
Brian B. Taylor, *Senate Committee Operations*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE OF
THE SENATE COMMITTEE ON EDUCATION AND HEALTH
AND
THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS
TO STUDY CERTIFICATE OF PUBLIC NEED
established pursuant to
The Rules of the Senate (Rule 20 (h) and Rule 20 (i))
and
The Rules of the House of Delegates (Rule 18 and Rule 22)
September 14, 1998, 10:00 A.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman, Senate Committee on Education and Health

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Comments on COPN and the Growth in Health Care Costs—
Paul M. Boynton, Executive Director
Eastern Virginia Health Systems Agency, Inc.

V. Potential Effects of Deregulation—
George L. Barker
Health Systems Agency of Northern Virginia

VI. Virginia Hospital and Health Care Association—
Katharine M. Webb, Senior Vice President

VII. Review of Certain Information and Literature—
Norma E. Szakal, Senior Attorney, Education and Health
Division of Legislative Services

VIII. Other Comments (At the Discretion of the Joint Subcommittee)

IX. Discussion and Direction to Staff, i.e., additional information, draft requests, etc.—
Joint Subcommittee

X. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman, Senate Committee on Education and Health*
Delegate Jay W. DeBoer, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Delegate Phillip A. Hamilton, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Senator Emily Couric
Senator John S. Edwards
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Delegate John H. Rust, Jr.

Staff:

Norma E. Szakal, *Senior Attorney, Education and Health, Division of Legislative Services*
Brenda H. Edwards, *Senior Research Associate, Education and Health, Division of Legislative Service*
Brian B. Taylor, *Senate Committee Operations*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE OF THE SENATE COMMITTEE ON EDUCATION AND HEALTH AND THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS TO STUDY CERTIFICATE OF PUBLIC NEED

established pursuant to
The Rules of the Senate (Rule 20 (h) and Rule 20 (i))
and
The Rules of the House of Delegates (Rule 18 and Rule 22)

November 12, 1998, 10:00 A.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Introductions—Norma E. Szakal, Senior Attorney

V. Joint Commission on Accreditation of Healthcare Organizations—
Kristin A. Hellquist, M.S.
Associate Director, Government Relations and External Affairs

Donna Nowakowski, M.S., R.N.
Director, State Relations

VI. American Association for Accreditation of Ambulatory Surgery Facilities—
Edward J. Stygar, Executive Director

VII. Accreditation Association for Ambulatory Health Care—
Brian P. Murray, M.D.
Virginia Beach Ambulatory Surgery Centers
Volunteer AAAHC Surveyor

VIII. Department of Medical Assistance Services—
The Honorable Dennis Smith, Director

IX. Responses to Call for Proposals and Issues and Alternatives—
Norma E. Szakal, Senior Attorney

X. Other Comments (at the discretion of the Joint Subcommittee)

XI. Discussion and Direction to Staff—Joint Subcommittee

XII. Adjournment

Over→

MEMBERS:

Senator Jane H. Woods, *Chairman*
Senate Committee on Education and Health

Delegate Jay W. DeBoer, *Co-Chairman*
House Committee on Health, Welfare and Institutions

Delegate Phillip A. Hamilton, *Co-Chairman*
House Committee on Health, Welfare and Institutions

Senator Emily Couric

Senator John S. Edwards

Delegate Kenneth R. Melvin

Senator Frederick M. Quayle

Delegate John H. Rust, Jr.

Staff:

Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Brenda H. Edwards, *Senior Research Associate, Education and Health*

Office of the Senate Clerk
Brian B. Taylor, *Senate Committee Operations*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE OF
THE SENATE COMMITTEE ON EDUCATION AND HEALTH
AND
THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS
TO STUDY CERTIFICATE OF PUBLIC NEED
established pursuant to
The Rules of the Senate (Rule 20 (h) and Rule 20 (i))
and
The Rules of the House of Delegates (Rule 18 and Rule 22)
January 12, 1999
2:00 P.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman, Senate Committee on Education and Health

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Legislative Alternatives—Norma E. Szakal, Senior Attorney, Division of Legislative Services

V. Discussion, Decisions, and Direction to Staff

VI. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman, Senate Committee on Education and Health*
Delegate Jay W. DeBoer, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Delegate Phillip A. Hamilton, *Co-Chairman, House Committee on Health, Welfare and Institutions*
Senator Emily Couric
Senator John S. Edwards
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Delegate John H. Rust, Jr.

Staff:
Norma E. Szakal, *Senior Attorney, Education and Health, Division of Legislative Services*
Brenda H. Edwards, *Senior Research Associate, Education and Health, Division of Legislative Services*
Brian B. Taylor, *Senate Committee Operations*

COMMONWEALTH OF VIRGINIA

SENATE

August 14, 1998

NEWS RELEASE
NOTICE OF PUBLIC HEARING

Administrative Contact
Brian Taylor
804-698-7450

Legislative Contact
Norma E. Szakal
804-786-3591

The Honorable Jane H. Woods, Chairman of the Special Joint Subcommittee to Study Certificate of Public Need, has announced a public hearing on Virginia's Medical Care Facilities Certificate of Public Need program to be held on Tuesday, August 25, 1998, at 6:30 p.m. in Senate Room B of the General Assembly building in Richmond. The Special Joint Subcommittee has been convened by the Chairmen of the Senate Committee on Education and Health and the House Committee on Health, Welfare and Institutions in accordance with the authority granted to standing committees and their chairmen by the Rules of the Virginia Senate, specifically, Rule 20 (h) and Rule 20 (i), and the Rules of the House of Delegates, specifically, Rule 18 and Rule 22. The Special Joint Subcommittee has established the following objectives for its study:

- **To examine** all aspects of the issues relating to the requirement for obtaining a certificate of public need for providing outpatient or ambulatory surgery.
- **To examine** all aspects of the issues relating to the requirement for obtaining a certificate of public need for purchases of major equipment to provide certain services, e.g., computed tomographic (CT) scanning, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), and positron emission tomographic (PET) scanning.
- **To examine** all aspects of the issues relating to the requirement for obtaining a certificate of public need for relocation of an existing facility.
- **To examine** such other issues relating to certificate of public need as may be relevant.
- **To provide** an opportunity for input from all relevant constituencies.
- **To seek** assistance from state agencies or other sources as may be necessary.
- **To make** recommendations to the Governor and the 1999 General Assembly concerning the certificate of public need program.

All interested parties are encouraged to attend the public hearing and present their views to the Special Joint Subcommittee. Speakers are advised that a five to seven minute limitation will apply. Persons wishing to speak are requested to register prior to the public hearing with Ms. Norma E. Szakal, Senior Attorney, Division of Legislative Services, at (804) 786-3591. Speakers are also requested to provide at least one copy of their remarks for the record.

COMMONWEALTH OF VIRGINIA

SUSAN CLARKE SCHAAR
CLERK OF THE SENATE
P O Box 396
RICHMOND VIRGINIA 23218

SENATE

September 24, 1998

NEWS RELEASE

Administrative Contact
Brian Taylor
804-698-7450

Legislative Contact
Norma E. Szakal
804-786-3591

The Honorable Jane H. Woods, Chairman, has announced, on behalf the Special Joint Subcommittee To Study Certificate of Public Need, the opportunity for all interested parties to submit written proposals relating to any Virginia laws relevant to certificate of public need and regulation of health facilities. Other members of the Special Joint Subcommittee are Delegates Jay W. DeBoer, Phillip A. Hamilton, Kenneth R. Melvin, and John H. Rust; and Senators Emily Couric, John S. Edwards, and Frederick M. Quayle.

Interested parties are requested to be concise and to submit written proposals by October 15 to Ms. Norma E. Szakal, Senior Attorney, Division of Legislative Services, 910 Capitol Street, Richmond, Va. 23219. Questions may be directed to Ms. Szakal at (804) 786-3591. Responders are advised that all proposals may be paraphrased for incorporation in a matrix for the November 12 meeting of the Special Joint Subcommittee.

Written proposals may involve specific amendments or alternatives to any relevant state law, alternatives or amendments to the COPN law or other health facility law, and any other changes or suggestions, including that there be no change in specific law. Responders are encouraged to consider the impact of their suggestions on access to health care, funding of indigent care, and the development of an efficient and effective health care system in Virginia.

APPENDIX D

1999 SPECIAL JOINT SUBCOMMITTEE CERTIFICATE OF PUBLIC NEED LEGISLATION

SB 1282 Medical care facilities certificate of public need.

Patron-Jane H. Woods

Summary as passed:

Medical care facilities certificate of public need. Eliminates the requirement for a certificate of public need for the replacement of any equipment; requires registration with the Commissioner of Health and the appropriate health systems agency, within 30 days of becoming contractually obligated, of purchases of any medical equipment for the provision of cardiac catheterization, computed tomographic scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging, magnetic source imaging, open heart surgery, positron emission tomographic scanning, radiation therapy, or other specialized service designated by the Board regulation; and revises the administrative process for obtaining a certificate.

The administrative procedures for review of applications for certificate of public need are revised to require (i) concise procedures for prompt review of applications; (ii) fees of one percent of the proposed expenditure for the project, with a minimum of $1,000 and a maximum of $20,000; (iii) transmission of the application by certified mail or a delivery service, return receipt requested, or delivery of the document by hand, with signed receipt to be provided; (iv) the 120-calendar-day review period must begin on the date upon which the application is determined to be complete within the batching process or, if the application is not determined to be complete within 40 calendar days from submission, the application must be refiled in the next batch for like projects; (v) the application review by the health systems agencies will be limited to 60 calendar days; (vi) the health systems agency must submit its recommendations on each application and its reasons within 10 calendar days after the completion of its 60-calendar-day review or such other period the applicant has requested; (vii) if the health systems agency does not complete its review within the 60-calendar-day period or the period requested by the applicant and submit its recommendations within the 10 calendar days after the completion of its review, the Department of Health must, on the 11th calendar day after the expiration of the health systems agency's review period, proceed as though the health systems agency has recommended project approval without conditions or revision; (viii) the Department and the Commissioner must begin the review of the application upon receipt of the completed application and simultaneously with the review conducted by the health systems agency. The Administrative Process Act will only apply to the COPN process in those instances for which timelines and specifications are not delineated in the COPN law, e.g., a formal hearing procedure. Upon accepting an application as complete, (i) the Department must establish a date for every application between 80 and 90 days within the 120-calendar-day review period for holding an informal fact-finding conference, if necessary; (ii) the Department must review every application at or before the 75th day within the 120-calendar-day period to determine whether an informal fact-finding conference is necessary; (iii) any informal fact-finding conference will be to consider the record and not a de novo review; (iv) in any case in which an informal fact-finding conference is held, a date must be established for the closing of the record in not more than 45 calendar days after the date of the conference; (v) in any case in which an informal fact-finding conference is not held, the record will be closed on the earlier of the date established for holding the conference or the date that the Department determines no conference is necessary; (vi) if the Commissioner's determination is not made within 15 calendar days of the closing of the record, he must notify the Attorney General and copy the parties and persons petitioning for good cause standing, in writing, that the application must be deemed approved unless the determination is made within 40 calendar days of the closing of the record; (vii) in any case in which the determination is not made within 40 calendar days after the closing of the record, the Department must refund 50 percent of the fee, the application will be deemed approved, and the certificate must be granted; (viii) if a determination is not made within 15 calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications may, prior to the application being deemed approved, institute a proceeding for mandamus against the Commissioner; (ix) if the writ of mandamus is granted, the Department will be liable for the costs and reasonable attorney's fees; and (x) upon the filing of a petition for mandamus, the relevant application will not be deemed approved, regardless of the time between the closing of the record and the final decision. Deemed approvals will be construed as the

Commissioner's case decision on the application pursuant to the Administrative Process Act and will be subject to judicial review on appeal as provided in the APA.

The Commissioner's annual report on COPN must include an analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department 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 within the timelines, the number of deemed approvals from the Department because of their failure to comply with the timelines, any other data determined by the Commissioner to be relevant to the efficient operation of the program, and an analysis of the equipment registrations, including the type of equipment replaced and purchased and the equipment costs. This bill is identical to HB 2369.

Full text:
01/21/99 Senate: Presented & ordered printed 999046760
01/28/99 Senate: Committee substitute printed 999101760-S1
02/26/99 Senate: Conference substitute printed 999157760-S2
03/12/99 Senate: Enrolled bill text (SB1282ER)
04/12/99 Governor: Acts of Assembly Chapter text (CHAP0899)

Amendments:
House amendments
Conference amendments

Status:
01/21/99 Senate: Presented & ordered printed 999046760
01/21/99 Senate: Referred to Committee on Education and Health
01/22/99 Senate: Assigned to Ed. & Health sub-committee: Health Care
01/28/99 Senate: Reported from Ed. & H. with substitute (15-Y 0-N)
01/28/99 Senate: Committee substitute printed 999101760-S1
01/29/99 Senate: Constitutional reading dispensed (40-Y 0-N)
01/29/99 Senate: VOTE: CONST. RDG. DISPENSED R (40-Y 0-N)
02/01/99 Senate: Read second time
02/01/99 Senate: Reading of substitute waived
02/01/99 Senate: Committee substitute agreed to 999101760-S1
02/01/99 Senate: Engrossed by Senate - comm. sub. 999101760-S1
02/04/99 Senate: Read third time and passed Senate (39-Y 0-N 1-A)
02/04/99 Senate: VOTE: PASSAGE (39-Y 0-N 1-A)
02/04/99 Senate: Communicated to House
02/06/99 House: Placed on Calendar
02/07/99 House: Read first time
02/07/99 House: Referred to Committee on Health, Welfare and Institutions
02/09/99 House: Assigned to H. W. I. sub-committee: 2
02/11/99 House: Reported from H. W. I. w/amendments (21-Y 0-N)
02/12/99 House: Read second time
02/15/99 House: Read third time
02/15/99 House: Committee amendments agreed to
02/15/99 House: Engrossed by House as amended
02/15/99 House: Passed House with amendments (99-Y 0-N)
02/15/99 House: VOTE: PASSAGE (99-Y 0-N 1-A)
02/17/99 Senate: Reading of amendments waived
02/17/99 Conference: House amendments rejected by conf. comm.
02/17/99 Senate: House amendments rejected by Senate (2-Y 37-N 1-A)
02/17/99 Senate: VOTE: REJECT HOUSE AMENDMENTS (2-Y 37-N 1-A)
02/18/99 House: House insisted on amendments
02/18/99 House: House requested conference committee
02/19/99 Senate: Senate acceded to request (37-Y 0-N 1-A)

02/19/99 Senate: VOTE: ACCEDE CONFERENCE COMM. (37-Y 0-N 1-A)
02/19/99 Senate: Conferees appointed by Senate
02/19/99 Senate: Senators: Woods, Couric, Martin
02/22/99 House: Conferees appointed by House
02/22/99 House: Delegates: Rust, Hamilton, DeBoer
02/26/99 House: Conference report agreed to by House (92-Y 0-N)
02/26/99 House: VOTE: ADOPTION (92-Y 0-N)
02/26/99 Conference: House amendments rejected by conf. comm.
02/26/99 Conference: Sub. recommended by conference comm. 999157760
02/26/99 Senate: Conference substitute printed 999157760-S2
02/26/99 Senate: Reading of conference report waived
02/26/99 Senate: Conference report agreed to by Senate (38-Y 0-N 1-A)
02/26/99 Senate: VOTE: CONF. COMMITTEE RPT (38-Y 0-N 1-A)
03/12/99 Senate: Enrolled bill text (SB1282ER)
03/15/99 Senate: Enrolled
03/16/99 Senate: Signed by President
03/18/99 House: Signed by Speaker
03/29/99 Governor: Approved by Governor-Chapter 899 (effective-see bill)
04/12/99 Governor: Acts of Assembly Chapter text (CHAP0899)

Go to (General Assembly Home) or (Bills and Resolutions)

CHAPTER 899

An Act to amend and reenact §§ 32.1-102.1, 32.1-102.2, 32.1-102.6, and 32.1-102.12 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-102.1:1, relating to medical care facilities certificate of public need.

[S 1282]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1, 32.1-102.2, 32.1-102.6, and 32.1-102.12 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-102.1:1 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. Intermediate care facilities.
5. Extended care facilities.
6. Mental hospitals.
7. Mental retardation facilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the Board by regulation.
10. Rehabilitation hospitals.
11. 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.

"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, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;

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

7. The addition ~~or replacement~~ 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. ~~Notwithstanding the provisions of this subdivision, the Commissioner shall develop regulations (i) providing for the replacement by a medical care facility of existing medical equipment, which is determined by the Commissioner to be inoperable or otherwise in need of replacement without requiring issuance of a certificate of public need, if the applicant agrees to such conditions as the Commissioner may establish; in compliance with regulations promulgated by the Board, requiring the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care; and (ii) providing for the replacement by a medical care facility of existing medical equipment without the issuance of a certificate of public need if the Commissioner has determined a certificate of public need has been previously issued for replacement of the specific equipment.~~ Replacement ~~or upgrade~~ of existing ~~magnetic resonance imaging (MRI)~~ *equipment* shall not ~~have to obtain~~ *require* a certificate of public need; or

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

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

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

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

§ 32.1-102.1:1. Equipment registration required.

Within thirty calendar days of becoming contractually obligated to acquire any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation, any person shall register such purchase with the Commissioner and the appropriate health systems agency.

§ 32.1-102.2. Regulations.

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

1. Shall establish *concise* procedures for the *prompt* review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects;

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

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

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

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care. In addition, the Board's licensure regulations shall direct the Commissioner to ~~consider, when~~ *condition the* issuing or renewing *of* any license for any applicant whose certificate was approved upon such condition~~,~~ *on* whether such applicant has complied with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

§ 32.1-102.6. Administrative procedures.

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

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

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

B. The appropriate health systems agency shall ~~begin to~~ review each ~~complete~~ *completed* application for a certificate within ~~such time as the Board may prescribe by regulation~~ *sixty calendar*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 32.1-102.12. Report required.

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

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

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

3. An analysis of the appropriateness of continuing the certificate of public need program for at

least ~~three~~ project categories in accordance with the five-year schedule for analysis of all project categories;

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

~~4.~~ *5.* An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

~~5.~~ *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; ~~and~~

~~6.~~ *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.

2. That an emergency exists and the provisions of this act amending and reenacting § 32.1-102.1 and adding § 32.1-102.1:1 are in force from its passage.

3. That, except for the provisions of this act amending and reenacting § 32.1-102.1 and adding § 32.1-102.1:1, the amendments in this act shall become effective on October 1, 1999.

4. That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999.

5. That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment.

HB 2369 Medical care facilities certificate of public need.

Patron-John H. Rust Jr.

Summary as passed:

Medical care facilities certificate of public need. Eliminates the requirement for a certificate of public need for the replacement of any equipment; requires registration with the Commissioner of Health and the appropriate health systems agency, within 30 days of becoming contractually obligated, of purchases of any medical equipment for the provision of cardiac catheterization, computed tomographic scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging, magnetic source imaging, open heart surgery, positron emission tomographic scanning, radiation therapy, or other specialized service designated by the Board regulation; and revises the administrative process for obtaining a certificate.

The administrative procedures for review of applications for certificate of public need are revised to require (i) concise procedures for prompt review of applications; (ii) fees of one percent of the proposed expenditure for the project, with a minimum of $1,000 and a maximum of $20,000; (iii) transmission of the application by certified mail or a delivery service, return receipt requested, or delivery of the document by hand, with signed receipt to be provided; (iv) the 120-calendar-day review period must begin on the date upon which the application is determined to be complete within the batching process or, if the application is not determined to be complete within 40 calendar days from submission, the application must be refiled in the next batch for like projects; (v) the application review by the health systems agencies will be limited to 60 calendar days; (vi) the health systems agency must submit its recommendations on each application and its reasons within 10 calendar days after the completion of its 60-calendar-day review or such other period the applicant has requested; (vii) if the health systems agency does not complete its review within the 60-calendar-day period or the period requested by the applicant and submit its recommendations within the 10 calendar days after the completion of its review, the Department of Health must, on the 11th calendar day after the expiration of the health systems agency's review period, proceed as though the health systems agency has recommended project approval without conditions or revision; (viii) the Department and the Commissioner must begin the review of the application upon receipt of the completed application and simultaneously with the review conducted by the health systems agency. The Administrative Process Act will only apply to the COPN process in those instances for which timelines and specifications are not delineated in the COPN law, e.g., a formal hearing procedure. Upon accepting an application as complete, (i) the Department must establish a date for every application between 80 and 90 days within the 120-calendar-day review period for holding an informal fact-finding conference, if necessary; (ii) the Department must review every application at or before the 75th day within the 120-calendar-day period to determine whether an informal fact-finding conference is necessary; (iii) any informal fact-finding conference will be to consider the record and not a de novo review; (iv) in any case in which an informal fact-finding conference is held, a date must be established for the closing of the record in not more than 45 calendar days after the date of the conference; (v) in any case in which an informal fact-finding conference is not held, the record will be closed on the earlier of the date established for holding the conference or the date that the Department determines no conference is necessary; (vi) if the Commissioner's determination is not made within 15 calendar days of the closing of the record, he must notify the Attorney General and copy the parties and persons petitioning for good cause standing, in writing, that the application must be deemed approved unless the determination is made within 40 calendar days of the closing of the record; (vii) in any case in which the determination is not made within 40 calendar days after the closing of the record, the Department must refund 50 percent of the fee, the application will be deemed approved, and the certificate must be granted; (viii) if a determination is not made within 15 calendar days of the closing of the record, any applicant who is competing in the relevant batch or who has filed an application in response to the relevant Request For Applications may, prior to the application being deemed approved, institute a proceeding for mandamus against the Commissioner; (ix) if the writ of mandamus is granted, the Department will be liable for the costs and reasonable attorney's fees; and (x) upon the filing of a petition for mandamus, the relevant application will not be deemed approved, regardless of the time between the closing of the record and the final decision. Deemed approvals will be construed as the Commissioner's case decision on the application pursuant to the Administrative Process Act and will be

subject to judicial review on appeal as provided in the APA.

The Commissioner's annual report on COPN must include an analysis of the effectiveness of the application review procedures used by the health systems agencies and the Department 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 within the timelines, the number of deemed approvals from the Department because of their failure to comply with the timelines, any other data determined by the Commissioner to be relevant to the efficient operation of the program, and an analysis of the equipment registrations, including the type of equipment replaced and purchased and the equipment costs. This bill is identical to SB 1282.

Full text:
01/21/99 House: Presented & ordered printed 999081760
02/03/99 House: Committee substitute printed 999114445-H1
02/19/99 Senate: Committee substitute printed 999147760-S1
02/26/99 House: Conference substitute printed 999159445-H2
03/12/99 House: Enrolled bill text (HB2369ER)
04/12/99 Governor: Acts of Assembly Chapter text (CHAP0922)

Amendments:
Conference amendments

Status:
01/21/99 House: Presented & ordered printed 999081760
01/21/99 House: Referred to Committee on Health, Welfare and Institutions
01/26/99 House: Assigned to H. W. I. sub-committee: 1
02/03/99 House: Reported from H. W. I. w/substitute (22-Y 0-N)
02/03/99 House: Committee substitute printed 999114445-H1
02/04/99 House: Read first time
02/05/99 House: Read second time
02/05/99 House: Committee substitute agreed to 999114445-H1
02/05/99 House: Engrossed by House - com. sub. 999114445-H1
02/06/99 House: Read third time and passed House (99-Y 0-N)
02/06/99 House: VOTE: PASSAGE (99-Y 0-N 1-A)
02/06/99 House: Communicated to Senate
02/08/99 Senate: Constitutional reading dispensed
02/08/99 Senate: Referred to Committee on Education and Health
02/18/99 Senate: Reported from Ed. & H. with substitute (15-Y 0-N)
02/19/99 Senate: Committee substitute printed 999147760-S1
02/22/99 Senate: Const. reading disp., passed by for the day (40-Y 0-N)
02/22/99 Senate: VOTE: CONST. RDG. DISPENSED R (40-Y 0-N)
02/23/99 Senate: Read third time
02/23/99 Senate: Reading of substitute waived
02/23/99 Senate: Committee substitute agreed to 999147760-S1
02/23/99 Senate: Passed by for the day
02/23/99 Senate: Reconsideration of pass by for the day agd. to (38-Y 0-N)
02/23/99 Senate: VOTE: RECONSIDER (38-Y 0-N)
02/23/99 Senate: Engrossed by Senate - comm. sub. 999147760-S1
02/23/99 Senate: Passed Senate with substitute (38-Y 0-N 1-A)
02/23/99 Senate: VOTE: PASSAGE (38-Y 0-N 1-A)
02/25/99 House: Placed on Calendar
02/25/99 House: Senate substitute rejected by House (2-Y 94-N 1-A)
02/25/99 House: VOTE: ADOPTION (2-Y 94-N 1-A)
02/25/99 Senate: Passed by temporarily
02/25/99 Senate: Senate insisted on substitute (39-Y 0-N 1-A)
02/25/99 Senate: VOTE: INSIST & REQUEST (39-Y 0-N 1-A)

02/25/99 Senate: Senate requested conference committee
02/26/99 House: House acceded to request
02/26/99 House: Conferees appointed by House
02/26/99 House: Delegates: Rust, Hamilton, DeBoer
02/26/99 Senate: Conferees appointed by Senate
02/26/99 Senate: Senators: Woods, Couric, Martin
02/26/99 House: Conference report agreed to by House (92-Y 0-N)
02/26/99 House: VOTE: ADOPTION (92-Y 0-N)
02/26/99 Conference: Senate amendment rejected by conf. comm.
02/26/99 Conference: Sub. recommended by conference comm. 999159445-H2
02/26/99 House: Conference substitute printed 999159445-H2
02/26/99 Senate: Reading of conference report waived
02/26/99 Senate: Conference report agreed to by Senate (40-Y 0-N)
02/26/99 Senate: VOTE: CONF. COMMITTEE RPT (40-Y 0-N)
03/12/99 House: Enrolled bill text (HB2369ER)
03/15/99 House: Enrolled
03/16/99 Senate: Signed by President
03/18/99 House: Signed by Speaker
03/29/99 Governor: Approved by Governor-Chapter 922 (effective-see bill)
04/12/99 Governor: Acts of Assembly Chapter text (CHAP0922)

Go to (General Assembly Home) or (Bills and Resolutions)

CHAPTER 922

An Act to amend and reenact §§ 32.1-102.1, 32.1-102.2, 32.1-102.6, and 32.1-102.12 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 32.1-102.1:1, relating to medical care facilities certificate of public need.

[H 2369]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That §§ 32.1-102.1, 32.1-102.2, 32.1-102.6, and 32.1-102.12 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 32.1-102.1:1 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. Intermediate care facilities.
5. Extended care facilities.
6. Mental hospitals.
7. Mental retardation facilities.
8. Psychiatric hospitals and intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts.
9. Specialized centers or clinics or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, radiation therapy, nuclear medicine imaging, or such other specialty services as may be designated by the Board by regulation.
10. Rehabilitation hospitals.
11. 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.

"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, substance abuse treatment, or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;

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

7. The addition ~~or replacement~~ 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. ~~Notwithstanding the provisions of this subdivision, the Commissioner shall develop regulations (i) providing for the replacement by a medical care facility of existing medical equipment, which is determined by the Commissioner to be inoperable or otherwise in need of replacement without requiring issuance of a certificate of public need, if the applicant agrees to such conditions as the Commissioner may establish, in compliance with regulations promulgated by the Board, requiring the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care; and (ii) providing for the replacement by a medical care facility of existing medical equipment without the issuance of a certificate of public need if the Commissioner has determined a certificate of public need has been previously issued for replacement of the specific equipment.~~ Replacement ~~or upgrade~~ of existing ~~magnetic resonance imaging (MRI)~~ *equipment* shall not ~~have to obtain~~ *require* a certificate of public need; or

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

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

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

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

§ 32.1-102.1:1. Equipment registration required.

Within thirty calendar days of becoming contractually obligated to acquire any medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, or other specialized service designated by the Board by regulation, any person shall register such purchase with the Commissioner and the appropriate health systems agency.

§ 32.1-102.2. Regulations.

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

1. Shall establish *concise* procedures for the *prompt* review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects;

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

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

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

B. The Board shall promulgate regulations providing for time limitations for schedules for completion and limitations on the exceeding of the maximum capital expenditure amount for all reviewable projects. The Commissioner shall not approve any such extension or excess unless it complies with the Board's regulations.

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care. In addition, the Board's licensure regulations shall direct the Commissioner to ~~consider,~~ ~~when~~ *condition the* issuing or renewing *of* any license for any applicant whose certificate was approved upon such condition~~,~~ *on* whether such applicant has complied with any agreement to provide a level of care at a reduced rate to indigents or accept patients requiring specialized care.

§ 32.1-102.6. Administrative procedures.

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

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

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

B. The appropriate health systems agency shall ~~begin to~~ review each ~~complete~~ *completed* application for a certificate within ~~such time as the Board may prescribe by regulation~~ *sixty calendar*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 32.1-102.12. Report required.

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

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

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

3. An analysis of the appropriateness of continuing the certificate of public need program for at

least three project categories in accordance with the five-year schedule for analysis of all project categories;

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

~~4.~~ *5.* An analysis of health care market reform in the Commonwealth and the extent, if any, to which such reform obviates the need for the certificate of public need program;

~~5.~~ *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; ~~and~~

~~6.~~ *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.

2. That an emergency exists and the provisions of this act amending and reenacting § 32.1-102.1 and adding § 32.1-102.1:1 are in force from its passage.

3. That, except for the provisions of this act amending and reenacting § 32.1-102.1 and adding § 32.1-102.1:1, the amendments in this act shall become effective on October 1, 1999.

4. That any applications for medical care facilities certificates of public need pending on October 1, 1999, for which the record has been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the record had closed on October 1, 1999. Applications for certificates of public need pending on October 1, 1999, for which the record has not been closed on or before October 1, 1999, shall be subject to the provisions of this act as if the applications were filed on October 1, 1999.

5. That the Board of Health shall promulgate regulations to implement the provisions of this act within 280 days of the date of its enactment.

SJ 496 Study; medical care facilities certificate of public need.

Patron-Jane H. Woods

Summary as passed:

Medical care facilities certificate of public need. Continues the special joint subcommittee to study Virginia's medical care facilities certificate of public need program and law. The special joint subcommittee is directed to evaluate (i) whether the certificate of public need program fulfills the goals of ensuring quality and access to health care services and containing costs by preventing the duplication of costly and unnecessary services; (ii) the effects of elimination of any certificate of public need requirements on access to care for the uninsured and underinsured in the Commonwealth; (iii) the interaction of modern health care financing, specifically, various forms of managed care, with the certificate of public need program; (vi) alternative regulatory or legal mechanisms which could be developed to provide accountability, access to care, quality assurance, and public input in the development of health care services, and to prevent redundant capitalization; (v) whether any part or all of the certificate of public need law should be repealed or if any segment of the health care industry which is presently covered by this law should be treated in a different manner; and (vi) any other issues relating to the certificate of public need law and its relationship to the health care industry and patient needs.

Full text:
01/21/99 Senate: Presented & ordered printed 999055760
03/08/99 Senate: Enrolled bill text (SJ496ER)

mendments:
House amendments

Status:
01/21/99 Senate: Presented & ordered printed 999055760
01/21/99 Senate: Referred to Committee on Rules
02/02/99 Senate: Reported from Rules
02/03/99 Senate: Reading waived (40-Y 0-N)
02/03/99 Senate: VOTE: (40-Y 0-N)
02/04/99 Senate: Read second time and engrossed
02/04/99 Senate: Reading waived (39-Y 0-N)
02/04/99 Senate: VOTE: (39-Y 0-N)
02/04/99 Senate: Agreed to by Senate by voice vote
02/04/99 Senate: Rec. of passage agreed to by Senate (39-Y 1-N)
02/04/99 Senate: VOTE: (39-Y 1-N)
02/04/99 Senate: Agreed to by Senate by voice vote
02/04/99 Senate: Communicated to House
02/06/99 House: Placed on Calendar
02/07/99 House: Referred to Committee on Rules
02/12/99 House: Assigned to Rules sub-committee: 3
02/22/99 House: Reported from Rules with amendment (15-Y 0-N)
02/24/99 House: Passed by for the day
02/25/99 House: Committee amendment agreed to
02/25/99 House: Engrossed by House as amended
02/25/99 House: Agreed to by House with amendment (Block Vote) (99-Y 1-N)
02/25/99 House: VOTE: BLOCK VOTE PASSAGE (99-Y 1-N)
02/25/99 Senate: Reading of amendment waived
02/25/99 Senate: House amendment agreed to by Senate by voice vote
03/08/99 Senate: Enrolled bill text (SJ496ER)
06/24/99 Senate: Study Committee Members Appointed

1999 SESSION

ENROLLED

SENATE JOINT RESOLUTION NO. 496

Continuing the Special Joint Subcommittee Studying Virginia's Medical Care Facilities Certificate of Public Need Program and Law.

Agreed to by the Senate, February 25, 1999
Agreed to by the House of Delegates, February 25, 1999

WHEREAS, Virginia's medical care facilities certificate of public need law (COPN) was originally enacted in 1973 for the specific legislative intent of providing for necessary services, ensuring the orderly development of the health care industry, and curtailing the development of duplicative services; and

WHEREAS, the federal National Health Planning and Resources Development Act was intended to establish health systems planning to meet the "needs" of the defined population, restrict the overbuilding of facilities, and address related issues such as primary care, medically underserved populations, multi-institutional systems, and improving access to care; and

WHEREAS, some experts aver that, in this age of ubiquitous managed care, COPN is no longer needed and that, in fact, there are few incentives for redundant capitalization, and that the restrictions on free enterprise are counterproductive and punitive; and

WHEREAS, other experts note that COPN is the only mechanism for public input into the rapid development of and changes in the health care system and emphasize the trend toward the fragmentation of the very health care systems developed in response to COPN through the development of "boutique" specialty provider services; and

WHEREAS, during the 1998 Session of the General Assembly, several bills resulted in intense debate on various issues relating to Virginia's certificate of public need program and law; and

WHEREAS, because of this debate, the chairmen of the relevant standing committees initiated a study of the certificate of public need issues pursuant to the authority granted by the Rules 20 (h) and 20 (i) of the Rules of the Virginia Senate and Rules 18 and 22 of the Rules of the House of Delegates; and

WHEREAS, the eight-member special joint subcommittee appointed to perform this task has met regularly and has conducted an extensive study of the issues, including research into the history and evolution of COPN in Virginia, testimony from the health care community and practitioners, and presentations from officials of the Joint Commission on Accreditation of Health Care Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities, and the Accreditation Association for Ambulatory Health Care; and

WHEREAS, the special joint subcommittee has accomplished much in its study and has made certain recommendations for revision of the COPN program in Virginia; and

WHEREAS, much data still needs to be obtained on the relationship between COPN and various reimbursement systems, including Medicaid, Medicare, and insurance, and analysis of the potential impact of revisions of the law must still be done to provide the basis for sound decisions; and

WHEREAS, the special joint subcommittee has, during the course of this work, come to recognize the complexity of the issues relating to COPN and the need for caution and thoroughness in resolving these issues; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Special Joint Subcommittee Studying Virginia's Medical Care Facilities Certificate of Public Need Program and Law be continued. The joint subcommittee shall be composed of 14 members: the 8 legislative members who served on the Special Joint Subcommittee during the 1998 interim shall continue to serve, and 6 citizen members shall be appointed as follows: one physician, one hospital representative, and one long-term care representative, to be appointed by the Senate Committee on Privileges and Elections, one physician, one hospital representative, and one health systems agency representative, to be appointed by the Speaker of the House. Vacancies shall be filled in the manner of the original appointment, execpt that appointments of members of the House of Delegates to fill vacancies shall also be in accordance with the principles of Rule 16 of the Rules of the House of Delegates.

In conducting its study, the special joint subcommittee shall evaluate:

1. Whether the certificate of public need program fulfills the goals of ensuring quality and access

to health care services and containing costs by preventing the duplication of costly and unnecessary services;

2. The effects of elimination of any certificate of public need requirements on access to care for the uninsured and underinsured in the Commonwealth;

3. The interaction of modern health care financing, specifically, various forms of managed care with the certificate of public need program;

4. Alternative regulatory or legal mechanisms which could be developed to provide accountability, access to care, quality assurances, and public input in the development of health care services, and to prevent redundant capitalization;

5. Whether any part or all of the certificate of public need law should be repealed or if any segment of the health care industry which is presently covered by this law should be treated in a different manner;

6. Any other issues relating to the certificate of public need law and its relationship to the health care industry and patient needs.

The direct costs of this study shall not exceed $10,800.

The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the special joint subcommittee, upon request.

The special joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

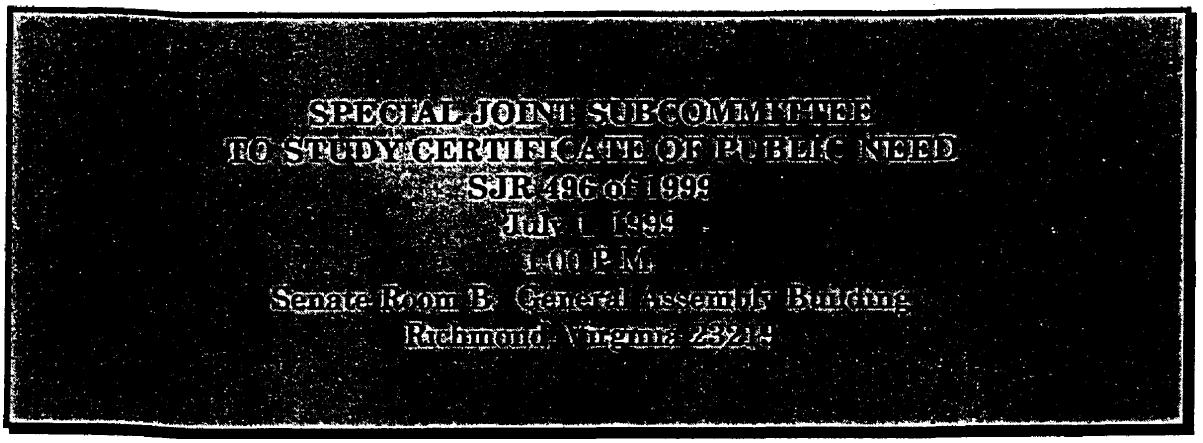
Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

APPENDIX E

STUDY AGENDAS

1999 INTERIM

Proposed Agenda



I. Call to Order—Senator Jane H. Woods, Chairman

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Study Status: Review of the Special Joint Subcommittee's 1998 Work and Recommendations—
Norma E. Szakal, Senior Attorney

V. 1999 Certificate of Public Need Legislation—
Norma E. Szakal, Senior Attorney

VI. 1999 Study Plan and Schedule—
Norma E. Szakal, Senior Attorney

VII. Audience Comments (at the discretion of the Joint Subcommittee)

VIII. Discussion and Direction to Staff—Joint Subcommittee

IX. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman*

Delegate Jay W. DeBoer, *Vice-Chairman*

Delegate Phillip A. Hamilton, *Vice-Chairman*

Senator Emily Couric

Senator John S. Edwards

Mr. Howard P. Kern

Delegate Kenneth R. Melvin

Senator Frederick M. Quayle

Dr. William L. Rich III

Dr. Elizabeth Weick Roycroft

Delegate John H. Rust, Jr.

Mr. J. Knox Singleton

Mr. Douglas C. Suddreth

Dr. H.W. Trieshmann, Jr.

Staff:

Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Michelle M. Montgomery, *Administrative Assistant, Education and Health*
Office of the Senate Clerk
Brian B. Taylor, Senate Committee Operations

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE
TO STUDY CERTIFICATE OF PUBLIC NEED
SJR 496 of 1999
July 28, 1999
1:00 P.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman

Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Implementation of the 1999 Certificate of Public Need Legislation—
Nancy R. Hofheimer, Director
Center for quality health Care Services and consumer Protection
Virginia Department of Health

V. Summary of Recent Regional Health Systems Agencies' Actions—
George L. Barker
Virginia Association of Regional Health Planning Agencies

VI. Review of Other States' 1999 COPN Legislation—
Norma E. Szakal, Senior Attorney

VII. Revised Study Plan, etc.—
Norma E. Szakal, Senior Attorney

VIII. Audience Comments (at the discretion of the Joint Subcommittee)

IX. Discussion and Direction to Staff—Joint Subcommittee

X. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman*

Delegate Jay W. DeBoer, *Vice-Chairman*

Delegate Phillip A. Hamilton, *Vice-Chairman*

Senator Emily Couric

Senator John S. Edwards

Mr. Howard P. Kern

Delegate Kenneth R. Melvin

Senator Frederick M. Quayle

Dr. William L. Rich III

Dr. Elizabeth Weick Roycroft

Delegate John H. Rust, Jr.

Mr. J. Knox Singleton

Mr. Douglas C. Suddreth

Dr. H.W. Trieshmann, Jr.

Staff:

Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Gwen Foley, *Senior Operations Staff Assistant, Education and Health*

Office of the Senate Clerk
Brian B. Taylor, *Senate Committee Operations Clerk*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE
TO STUDY CERTIFICATE OF PUBLIC NEED
SJR 496 of 1999
November 15, 1999
1:00 P.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Annual Report on the Status of Virginia's Certificate of Need Program (§ 32.1-102.12)—
Dr. Clydette Powell, M.D., M. Ph.
Deputy Commissioner for Policy
Virginia Department of Health

V. Virginia Indigent Health Care Trust Fund—
C. Mack Brankley, Director
Program Operations
Department of Medical Assistance Services

VI. Anesthesia in the Practitioner's Office—
Dr. Ronald L. Tankersley (Oral surgeon)
Dr. Roger E. Wood (Pediatric Dentist)

VII. Statement of The Medical Society of Virginia—
Michael Jurgensen, Director
Health Policy and Medical Economics
The Medical Society of Virginia

VIII. The Balanced Budget Act of 1997—
Christopher S. Bailey
Senior Vice President
The Virginia Hospital and Health Care Association

→ → → **OVER** → → →

IX. Additional Data on Outpatient Surgical Procedures—
George L. Barker
Virginia Association of Regional Health Planning Agencies

X. Fifty-State Telephone Survey: Certificate of Need and Health Policy—
Norma E. Szakal, Senior Attorney Education and Health

XI. Audience Comments (at the discretion of the Joint Subcommittee)

XII. Discussion and Direction to Staff—Joint Subcommittee

XIII. Adjournment

MEMBERS:

Senator Jane H. Woods, *Chairman*
Delegate Jay W. DeBoer, *Vice-Chairman*
Delegate Phillip A. Hamilton, *Vice-Chairman*
Senator Emily Couric
Senator John S. Edwards
Mr. Howard P. Kern
Delegate Kenneth R. Melvin
Senator Frederick M. Quayle
Dr. William L. Rich III
Dr. Elizabeth Weick Roycroft
Delegate John H. Rust, Jr.
Mr. J. Knox Singleton
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Dr. H.W. Trieshmann, Jr.

Staff:
Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Gwen Foley, *Senior Operations Staff Assistant, Education and Health*

Office of the Senate Clerk
Brian B. Taylor, *Senate Committee Operations Clerk*

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE
TO STUDY CERTIFICATE OF PUBLIC NEED
SJR 496 of 1999
December 8, 1999
2:00 P.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Legislative Drafts/Alternatives—
Norma E. Szakal, Senior Attorney

V. Audience Response to the Legislative Drafts/Alternatives—

VI. From the Physicians' Viewpoint: Outpatient Endoscopy—
Dr. Michael Garone
Dr. Lynn Duffy

VII. Additional Public Comments (at the discretion of the Joint Subcommittee)

VIII. Discussion and Direction to Staff—Joint Subcommittee

IX. Adjournment

OVER
→→→→→→→→→→

MEMBERS:

Senator Jane H. Woods, *Chairman*

Delegate Jay W. DeBoer, *Vice-Chairman*

Delegate Phillip A. Hamilton, *Vice-Chairman*

Senator Emily Couric

Senator John S. Edwards

Mr. Howard P. Kern

Delegate Kenneth R. Melvin

Senator Frederick M. Quayle

Dr. William L. Rich III

Dr. Elizabeth Weick Roycroft

Delegate John H. Rust, Jr.

Mr. J. Knox Singleton

Mr. Douglas C. Suddreth

Dr. H.W. Trieshmann, Jr.

Staff:

Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Gwen Foley, *Senior Operations Staff Assistant, Education and Health*
Office of the Senate Clerk
Brian B. Taylor, Senate Committee Operations

Proposed Agenda

SPECIAL JOINT SUBCOMMITTEE
TO STUDY CERTIFICATE OF PUBLIC NEED
SJR 496 of 1999
January 5, 2000
10:00 A.M.
Senate Room B, General Assembly Building
Richmond, Virginia 23219

I. Call to Order—Senator Jane H. Woods, Chairman

II. Introduction of Members—Chairman

III. Opening Remarks—Chairman

IV. Review of Legislative Drafts, Revisions, and Alternatives—
Norma E. Szakal, Senior Attorney

V. Public Comment of Legislative Drafts—

VI. Discussion, Decisions, and Direction to Staff—Joint Subcommittee

VIII. Adjournment

OVER
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MEMBERS:

Senator Jane H. Woods, *Chairman*

Delegate Jay W. DeBoer, *Vice-Chairman*

Delegate Phillip A. Hamilton, *Vice-Chairman*

Senator Emily Couric

Senator John S. Edwards

Mr. Howard P. Kern

Delegate Kenneth R. Melvin

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Dr. William L. Rich III

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Delegate John H. Rust, Jr.

Mr. J. Knox Singleton

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Dr. H.W. Trieshmann, Jr.

Staff:

Division of Legislative Services
Norma E. Szakal, *Senior Attorney, Education and Health*
Gwen Foley, *Senior Operations Staff Assistant, Education and Health*
Office of the Senate Clerk
Brian B. Taylor, Senate Committee Operations

APPENDIX F

OPERATING ROOM DATA

PRESENTATION MADE BY
THE DEPARTMENT OF HEALTH

1998 INTERIM STUDY

OPERATING ROOMS IN GENERAL HOSPITALS
1997 INVENTORY AND 1995-97 UTILIZATION

HPR	PD	FACILITY	General ORs	Other ORs	1995 Proced.	1995 Hours	1996 Proced.	1996 Hours	1997 Proced.	1997 Hours
I	6	Augusta Medical Center	10	4	8,942	11,467	8,694	12,624	8,963	14,750
		Bath Community Hospital	1	0	127	172	76	224	33	59
		Rockingham Mem. Hospital	7	2	10,973	15,800	10,990	16,706	11,295	15,648
		Stonewall Jackson Hospital	3	0	1,253	1,554	1,306	NR	1,398	NR
		Total PD 6	**21**	**6**	**21,295**	**28,993**	**21,066**	NA	**21,689**	NA
	7	Page Memorial Hospital	1	1	313	333	501	834	1,266	1,060
		Shenandoah County Mem. Hosp.	4	2	2,308	1,994	2,534	2,677	2,194	3,118
		Warren Memorial Hospital	3	3	1,862	3,444	1,848	4,652	1,990	4,966
		Winchester Medical Center	7	1	6,833	13,195	7,110	14,876	7,672	15,854
		Total PD 7	**15**	**7**	**11,316**	**18,966**	**11,993**	**23,039**	**13,122**	**24,998**
	9	Culpeper Memorial Hospital	2	1	2,281	5,006	2,101	4,689	2,183	5,076
		Fauquier Hospital	3	1	3,262	6,220	3,100	5,553	3,356	5,913
		Total PD 9	**5**	**2**	**5,543**	**11,226**	**5,201**	**10,242**	**5,539**	**10,989**
	10	Martha Jefferson Hospital	10	5	7,063	14,200	7,099	11,867	6,977	8,786
		University of Virginia Hospitals	18	2	13,411	45,615	13,578	45,156	14,094	37,932
		Total PD 10	**6**	**2**	**20,474**	**59,815**	**20,677**	**57,023**	**21,071**	**46,718**
	16	Mary Washington Hospital	9	4	9,537	18,678	10,438	20,225	10,994	22,714
		Total PD 16	**9**	**4**	**9,537**	**18,678**	**10,438**	**20,225**	**10,994**	**22,714**
		Total HPR I	**55**	**21**	**68,166**	**137,678**	**69,375**	NA	**72,415**	NA
II	8	Alexandria Hospital	11	1	10,700	19,461	10,366	19,406	10,443	19,518
		Arlington Hospital	14	6	9,554	NR	12,333	NR	10,810	11,583
		Fair Oaks Hospital	6	2	9,949	13,321	10,842	14,348	10,650	14,387
		Fairfax Hospital	27	7	28,259	57,568	29,201	61,302	30,424	62,779
		Reston Hospital Center	9	4	7,895	16,096	9,688	18,218	11,115	19,548
		Loudoun Hospital Center	4	4	4,952	8,449	5,160	8,263	6,673	10,803
		Mount Vernon Hospital	7	3	6,590	NR	8,461	NR	9,910	NR
		Pentagon City Hospital	6	1	2,168	NR	2,394	4,031	2,167	3,207
		Vencor Hospital	6	5	1,616	3,409	3,656	6,910	3,690	7,513
		Potomac Hospital	5	7	8,114	12,137	8,579	12,531	9,212	12,820
		Prince William Hospital	5	1	4,832	7,757	6,288	8,308	4,968	8,615
		Total HPR II	**100**	**41**	**94,629**	**NA**	**106,968**	**NA**	**110,062**	**NA**
III	1	Lee County Community Hospital	2	1	1,444	2,617	1,835	3,249	2,069	3,458
		Lonesome Pine Hospital	2	2	1,078	2,146	1,227	888	892	1,640
		Norton Community Hospital	3	2	1,739	3,139	2,224	3,889	2,271	3,753
		St. Mary's Hospital	2	1	1,945	5,130	2,047	5,413	2,167	5,726
		Wise Appalachian Regional Hosp.	2	1	2,451	8,058	1,991	2,459	1,457	3,917

OPERATING ROOMS IN GENERAL HOSPITALS
1997 INVENTORY AND 1995-97 UTILIZATION

HPR	PD	FACILITY	General ORs	Other ORs	1995 Proced.	1995 Hours	1996 Proced.	1996 Hours	1997 Proced.	1997 Hours
		Total PD 1	**11**	**7**	**8,667**	**21,090**	**9,324**	**16,898**	**8,866**	**18,494**
	2	Buchanan General Hosp.-Grundy	2	2	1,501	2,697	1,370	1,350	1,277	1,677
		Clinch Valley Med. Center	3	1	2,796	3,744	2,889	3,968	2,869	4,990
		Dickenson County Medical Center	2	1	848	1,373	721	2,717	838	4,190
		Russell County Medical Center	3	0	1,309	2,918	1,517	3,382	1,788	3,595
		Tazewell Community Hospital	2	0	583	1,769	882	2,767	936	2,723
		Total PD 2	**12**	**4**	**7,037**	**12,601**	**7,379**	**14,184**	**7,708**	**17,176**
	3	Johnston Memorial Hospital	4	3	5,823	NR	5,694	NR	5,873	NR
		Smyth County Community Hosp.	4	1	2,686	3,083	3,682	3,806	2,932	NR
		Twin County Community Hospital	3	3	4,261	5,752	4,142	6,301	4,055	6,453
		Wythe County Community Hosp.	3	1	2,459	4,063	2,816	4,029	2,973	4,070
		Total PD 3	**14**	**8**	**16,229**	NA	**16,334**	NA	**15,833**	NA
	4	Giles Memorial Hospital	2	0	1,733	2,140	942	1,364	986	1,395
		Montgomery Regional Hospital	5	3	3,259	6,690	4,446	5,783	4,748	6,169
		Pulaski Community Hospital	4	1	2,421	2,794	2,497	3,621	2,215	3,175
		Radford Community Hospital	6	3	5,777	6,937	5,704	8,706	7,250	8,815
		Total PD 4	**17**	**7**	**13,190**	**18,561**	**13,589**	**19,474**	**15,199**	**19,554**
	5	Alleghany Regional Hospital	6	3	4,837	9,603	4,846	9,843	4,741	7,104
		Roanoke Community Hospital	10	4	12,257	20,051	11,584	18,709	13,405	15,935
		Lewis-Gale Medical Center	9	5	6,520	10,986	7,119	9,575	9,066	13,284
		Roanoke Memorial Hospital	15	4	15,802	34,495	16,611	32,357	16,108	27,900
		Total PD 5	**40**	**16**	**39,416**	**76,135**	**40,160**	**70,484**	**43,320**	**64,223**
	11	Bedford County Memorial Hosp.	2	2	1,477	3,890	1,453	3,553	1,462	3,431
		Lynchburg General Hospital	8	1	6,941	15,465	7,399	14,012	7,691	14,583
		Virginia Baptist Hospital	8	5	11,513	20,775	12,033	20,574	12,327	20,247
		Total PD 11	**18**	**8**	**19,931**	**40,130**	**20,885**	**38,139**	**21,480**	**38,261**
	12	Danville Regional Med. Center	8	6	7,475	13,085	14,264	27,720	11,678	16,160
		Franklin Memorial Hospital	2	1	1,237	2,353	1,338	2,525	1,305	1,388
		Mem. Hosp. Martinsville/Henry	6	2	5,010	7,768	5,027	7,544	5,220	7,606
		R.J. Reynolds Hospital	2	0	812	733	642	551	389	378
		Total PD 12	**18**	**9**	**14,534**	**23,939**	**21,271**	**38,340**	**18,592**	**26,632**
		Total HPR III	**130**	**59**	**117,994**	**NA**	**128,942**	**NA**	**130,988**	**NA**
IV	13	Community Memorial Health Center	2	1	2,805	5,239	3,106	4,635	3,317	6,546
		Halifax Regional Hospital	3	3	3,249	3,261	4,869	4,152	3,396	5,344
		Total PD 13	**5**	**4**	**6,054**	**8,500**	**7,975**	**8,787**	**6,713**	**11,890**
	14	Southside Community Hospital	3	3	3,639	5,578	3,691	4,246	3,913	5,692
		Total PD 14	**3**	**3**	**3,639**	**5,678**	**3,691**	**4,246**	**3,913**	**5,692**

OPERATING ROOMS IN GENERAL HOSPITALS
1997 INVENTORY AND 1995-97 UTILIZATION

HPR	PD	FACILITY	General ORs	Other ORs	1995 Proced.	1995 Hours	1996 Proced.	1996 Hours	1997 Proced.	1997 Hours
	15	Chippenham Medical Center	14	4	12,103	23,512	13,627	22,485	16,328	20,647
		HealthSouth Medical Center	8	5	6,063	5,904	6,875	9,537	9,082	7,114
		Henrico Doctors Hospital	17	5	12,843	25,359	14,909	24,620	16,339	26,036
		Johnston-Willis Hospital	14	5	16,129	30,112	15,881	16,213	18,325	19,660
		MCV Hospitals	22	1	15,059	46,874	10,410	31,619	11,155	44,174
		Capitol Medical Center	3	2	843	1,351	1,112	1,677	1,191	1,636
		Retreat Hospital	6	4	4,042	9,655	6,043	8,656	5,676	7,891
		Richmond Community Hospital	2	2	542	926	1,094	1,419	1,144	1,925
		Richmond Eye & Ear Hospital	6	0	4,665	8,116	4,320	7,613	4,393	6,973
		Richmond Memorial Hospital	9	4	8,573	14,008	7,690	12,416	7,507	11,316
		St. Mary's Hosp., Richmond	20	1	24,979	51,662	26,805	52,871	19,559	38,277
		Stuart Circle Hospital	6	2	4,851	7,858	5,264	8,541	4,775	4,586
		Children's Hospital	2	0	644	287	596	NA	739	2,032
		Total PD 15	**129**	**36**	**111,336**	**226,624**	**114,626**	**NA**	**116,213**	**192,267**
	19	Greensville Mem. Hospital	2	1	1,261	1,548	1,375	1,786	1,484	1,864
		John Randolph Medical Center	3	3	5,841	6,719	5,894	6,818	6,161	7,519
		Southside Regional Med. Center	8	1	8,908	14,126	9,336	13,320	5,914	9,576
		Total PD 19	**13**	**5**	**16,010**	**22,393**	**16,605**	**21,924**	**13,559**	**18,959**
		Total HPR IV	**160**	**47**	**137,039**	**262,095**	**142,897**	**NA**	**140,398**	**228,808**
V	17	Rappahannock General Hospital	2	1	2,456	2,708	2,609	5,188	2,651	3,874
		Total PD 17	**2**	**1**	**2,456**	**2,708**	**2,609**	**5,188**	**2,651**	**3,874**
	18	Riverside Tappahannock Hospital	3	1	1,329	NR	1,662	NR	2,939	NR
		Riverside Walter Reed Hospital	2	0	1,695	2,904	1,588	2,525	1,352	1,994
		Total PD 18	**5**	**1**	**3,024**	**NA**	**3,250**	**NA**	**4,291**	**NA**
	20	Chesapeake General Hospital	10	4	15,494	20,331	15,380	20,933	17,242	25,473
		Children's Hosp. King's Daughters	8	1	6,674	10,781	6,489	10,527	6,915	8,813
		DePaul Medical Center	10	5	8,459	12,956	8,494	12,930	8,648	12,377
		Louise Obici Memorial Hospital	8	1	4,667	8,089	4,984	8,555	5,536	9,510
		Norfolk Community Hospital	3	1	1,837	5,122	1,842	3,439	1,666	3,908
		Portsmouth General Hospital	8	3	7,286	10,559	8,402	11,456	6,243	8,929
		Maryview Medical Center	10	3	9,464	14,305	10,696	17,207	11,990	23,015
		Sentara Bayside Hospital	7	2	8,068	15,420	7,886	12,373	7,346	11,956
		Sentara Leigh Hospital	11	4	10,555	16,364	10,661	16,579	11,582	17,202
		Sentara Norfolk General Hospital	23	4	19,442	52,139	14,353	39,082	19,508	45,386
		Southampton Memorial Hospital	3	1	2,621	3,196	2,592	3,156	2,520	3,203
		Virginia Beach General Hospital	9	5	4,618	5,911	10,564	21,215	11,805	23,166
		Total PD 20	**110**	**34**	**99,186**	**176,173**	**102,343**	**177,462**	**111,001**	**192,938**

OPERATING ROOMS IN GENERAL HOSPITALS
1997 INVENTORY AND 1995-97 UTILIZATION

HPR	PD	FACILITY	General ORs	Other ORs	1995 Proced.	1995 Hours	1996 Proced.	1996 Hours	1997 Proced.	1997 Hours
	21	Mary Immaculate Hospital	8	4	8,696	8,698	9,019	9,814	9,377	10,847
		Newport News General Hospital	NR	NR	761	952	NR	NR	NR	NR
		Riverside Regional Med. Center	13	1	12,084	22,852	11,831	22,596	11,768	23,043
		Sentara Hampton General Hospital	7	4	9,821	13,033	8,618	13,433	6,857	11,405
		Williamsburg Community Hospital	7	2	6,736	9,420	6,775	11,239	7,008	10,635
		Total PD 21	**NA**	**NA**	**38,098**	**54,955**	**NA**	**NA**	**NA**	**NA**
	22	Shore Memorial Hospital	3	1	2,161	2,943	2,412	2,880	2,881	3,913
		Total PD 22	**3**	**1**	**2,161**	**2,943**	**2,412**	**2,880**	**2,881**	**3,913**
		Total HPR V	**NA**	**NA**	**144,924**	**NA**	**NA**	**NA**	**NA**	**NA**
		TOTAL VIRGINIA	**NA**	**NA**	**562,751**	**NA**	**NA**	**NA**	**NA**	**NA**

Source: Annual Survey of Hospitals, 1995-1997
Virginia Department of Health, Div. of COPN

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PATIENT SURGICAL HOSPITALS
1997 INVENTORY AND 1995-97 UTILIZATION

HPR	PD	Facility	Gen. ORs	Minor ORs	1995 Proced.	1995 Hours	1996 Proced.	1996 Hours	1997 Proced.	1997 Hours
I	7	Surgi-Center of Winchester*	4	0	5,084	5,126	5,280	4,810	5,500	2,742
	10	Virginia A. S. C. (Charlottesville)	6	0	4,243	7,409	4,716	6,815	5,181	7,171
	16	Fredericksburg A.S.C.	3	0	4,844	3,465	5,092	3,787	5,577	4,237
	16	Surgi-Center of Central Virginia	2	0	1,429	1,672	1,606	1,974	1,673	2,040
		Total Health Planning Region I	**15**	**0**	**15,600**	**17,672**	**16,694**	**17,386**	**17,931**	**16,190**
II	8	Countryside A. S. C.	3	1	1,775	2,662	2,027	4,056	2,214	2,018
		Inova Surgery Center - Fairfax Hospital	6	0	7,869	12,224	8,169	7,599	8,375	10,638
		Columbia Fairfax Surgical Center	6	0	4,208	NR	6,074	8,238	6,386	6,525
		Falls Church A.S.C.-Kaiser Permanente	4	2	8,609	7,904	8,207	9,096	8,618	9,942
		Total Health Planning Region II	**19**	**3**	**20,686**	**NA**	**22,460**	**24,933**	**23,379**	**27,105**
III	5	Lewis-Gale Clinic	4	0	5,088	5,477	6,453	6,729	6,006	6,261
	12	Piedmont Day Surgery Center	1	0	494	717	444	886	313	691
		Total Health Planning Region III	**5**	**0**	**5,582**	**6,194**	**6,897**	**7,615**	**6,319**	**6,952**
IV	15	Cataract & Refractive Surgical Center	1	0	1,281	1,475	1,266	1,435	1,375	1,555
		Columbia Hanover Outpatient Center	2	0	729	729	1,285	1,928	2,078	2,103
		Tuckahoe Surgery Center	2	1	1,688	2,157	1,542	2,034	1,792	2,489
		Urosurgical Center of Richmond	1	2	1,599	2,701	1,713	2,603	2,299	3,494
		Urosurgical Center of Richmond South	1	2	1,557	2,446	1,952	NR	1,782	2708
		Urosurgical Center of Richmond North	1	2	902	1,431	1,982	3,086	2,171	3,380
		Virginia Eye Institute	2	3	3,410	1,891	3,636	2,140	4,341	2,454
		Virginia Heart Institute	1	0	59	224	36	140	49	196
		Total Health Planning Region IV	**11**	**10**	**11,225**	**13,054**	**13,612**	**NA**	**16,887**	**18,379**
V	20	Ambulatory Surgery Center (Sentara)	6	0	4,187	4,172	4,068	4,144	4,228	5,361
		Virginia Beach A.S.C.	4	0	4,618	5,911	4,412	5,648	4,735	6,156
		Lakeview Medical A. S. C.	2	3	2,457	1,397	3,184	1,742	3,180	1,786
	21	Sentara CarePlex	2	2	1,352	1,622	1,952	2,008	2,369	2,434
	21	Riverside Surgery Center	4	0	2,503	NR	2,880	NR	3,663	3,486
		Total Health Planning Region V	**18**	**5**	**15,117**	**NA**	**16,496**	**NA**	**18,175**	**19,223**
		Total Virginia	68	18	68,210	NA	76,149	NA	81,691	87,849

Source: Annual Survey of Hospitals, 1995 - 1997, Division of Certificate of Public Need

PROJECTED NEED FOR OPERATING ROOMS - 2001
VIRGINIA

HPR	PD	A. Total OR Visits '95-'97	B. Projected Population '95-'97	C. Surgical Use Rate (A/B)	D. Projected Population 2001	E. Projected OR Visits 2001 (C x D)	F. Total OR Hours 1997	G. Avg. Hrs./ OR Visit 1997	H. OR Hours Needed 2001 (E x G)	I. ORs Needed 2001 (H/1600)	J. Current ORs 1997	K. Net OR Need (J - I)
I	6	64,050	696,158	0.092	238,368	21,931	30,457	1.40	30,797	19	27	-8
	7	52,363	522,289	0.100	188,191	18,867	27,740	1.49	28,106	18	26	-8
	9	16,283	396,728	0.041	146,395	6,009	10,989	1.98	11,920	7	7	0
	10	76,362	528,045	0.145	186,915	27,030	53,889	2.05	55,487	35	41	-6
	16	52,587	596,063	0.088	222,503	19,630	29,031	1.55	30,423	19	18	1
Total	**HPR I**	**261,645**	**2,739,283**	**0.096**	**982,372**	**93,467**	**152,106**	**1.67**	**156,732**	**98**	**119**	**-21**
II	8	384,188	4,911,441	0.078	1,782,641	139,436	199,896	1.47	205,470	128	163	-35
III	1	26,837	268,018	0.100	87,409	8,752	18,494	2.09	18,278	11	18	-7
	2	22,122	363,618	0.063	113,252	7,085	17,175	2.23	15,787	10	16	-6
	3	47,396	534,001	0.089	177,620	15,765	10,523	0.66	10,478	7	22	-15
	4	41,978	470,693	0.089	160,685	14,330	19,554	1.29	18,437	12	24	-12
	5	142,882	762,930	0.187	254,827	47,724	70,484	1.43	68,195	43	60	-17
	11	62,296	641,157	0.097	220,598	21,434	38,261	1.78	38,178	24	26	-2
	12	55,758	719,591	0.077	240,741	18,654	26,223	1.39	25,875	16	28	-12
Total	**HPR III**	**399,269**	**3,760,008**	**0.106**	**1,255,132**	**133,745**	**200,714**	**1.46**	**196,227**	**122**	**194**	**-72**
IV	13	20,742	242,305	0.086	80,381	6,881	11,890	1.77	12,187	8	9	-1
	14	11,243	257,872	0.044	86,817	3,785	5,692	1.45	5,506	3	6	-3
	15	382,047	2,400,574	0.159	857,401	136,454	213,390	1.62	220,423	138	185	-47
	19	46,174	471,981	0.098	157,976	15,455	18,959	1.40	21,610	14	18	-4
Total	**HPR IV**	**460,206**	**3,372,732**	**0.136**	**1,182,575**	**162,575**	**249,931**	**1.60**	**259,726**	**162**	**218**	**-56**
V	17	7,716	137,729	0.056	47,562	2,665	3,874	1.46	3,894	2	3	-1
	18	10,565	241,714	0.044	87,379	3,819	1,994	0.46	1,775	1	6	-5
	20	366,281	3,283,856	0.108	1,171,685	127,122	206,241	1.67	212,903	133	158	-25
	21	121,701	1,290,430	0.094	453,394	42,760	61,877	1.60	68,416	43	54	-11
	22	7,454	134,539	0.055	44,837	2,484	3,913	1.36	3,374	2	4	-2
Total	**HPR V**	**503,717**	**5,088,268**	**0.099**	**1,804,867**	**178,849**	**277,899**	**1.62**	**290,361**	**181**	**225**	**-44**
VIRGINIA		2,009,025	19,861,732	0.101	7,007,477	708,072	1,080,546	1.56	1,107,517	692	919	-227

Source: Annual Survey of Hospitals, 1997, Virginia Department of Health, DCOPN
Virginia Employment Commission Population Projections 2010, & Population Projection Interpolations for 1995-1999

CJM
6/27/1998

CERTIFICATE OF PUBLIC NEED ACTIVITY
OUTPATIENT SURGICAL HOSPITALS
1992 - 1998

Year	Project/Sponsor	Location	Decision	Primary Sponsor	Comments
1992	Establish an outpatient surgical hospital Retreat Hospital	Hanover County	Denial	Hospital	New ORs
	Establish an outpatient surgical hospital Richmond Memorial Hospital	Hanover County	Approval	Hospital	Relocation of ORs Followed denial of request to establish new gen. hospital
	Establish an outpatient surgical hospital Sentara Hampton General Hospital	Hampton	Approval	Hospital	Relocation of ORs
1993	Expand an outpatient surgical hospital Surgicenter of Winchester	Winchester	Approval	Hospital	New OR
	Establish an outpatient surgical hospital Retreat Hospital	Hanover County	Approval	Hospital	Relocation of ORs
	Establish an outpatient surgical hospital Urosurgical Center of Richmond	Hanover County	Approval	Physician	New ORs
	Expand an outpatient surgical hospital Virginia Ambulatory Surgery Center	Charlttsville.	Approval	Hospital	New ORs
	Establish an outpatient surgical hospital Alexandria Health Services Corp.	Alexandria	Denial	Hospital	New ORs
1994	Establish an outpatient surgical hospital Surgical Care Affiliates/Nashville, TN	Alexandria	Withdrawn	Corporate	New ORs - joint venture with surgeons negative review by reviewing agencies
	Renovate an outpatient surgical hospital Surgicenter of Winchester	Winchester	Approval	Hospital	No OR expansion
1995	Establish an outpatient surgical hospital Tidewater Urology Surgery Center	Norfolk	Denial	Physician	New ORs
	Establish an outpatient surgical hospital Gastroenterology Consultants, Ltd.	Va. Beach	Denial	Physician	New ORs
	Renovate an outpatient surgical hospital Lewis-Gale Clinic	Salem	Approval	Physician	Convert special ORs to general ORs

1995 (cont.)	Expand an outpatient surgical hospital Lewis-Gale Clinic	Salem	Denial	Physician	New ORs
	Establish an outpatient surgical hospital Virginia Beach Endoscopy Center	Va. Beach	Withdrawn	Corporate	New ORs
	Establish an outpatient surgical hospital Alexandria Surgi-Center, L.P.	Alexandria	Denial	Physician	New ORs
	Establish an outpatient surgical hospital Fairfax Endoscopy Center Gen. Partners	Fairfax County	Denial	Corporate	New ORs
1996	Expand an outpatient surgical hospital Fredericksburg Amb. Surgery Center	Fredrckbrg.	Denial	Hospital	New OR
	Establish an outpatient surgical hospital Snowden Medical Center, Inc.	Fredrckbrg.	Denial	Physician	New ORs
	Establish an outpatient surgical hospital Springfield Surgery Center, Inc.	Fairfax County	Approval	Hospital	Relocation of ORs Hospital joint venture
	Expand a general hospital Fairfax Hospital	Fairfax County	Approval	Hospital	Relocation of ORs replacement of out-patient surgical hosp.
	Expand an outpatient surgical hospital Virginia Eye Institute	Richmond	Withdrawn	Physician	New ORs - negative recommendations by reviewing agencies
1997	Establish an outpatient surgical hospital Harman Eye Center	Bedford County	Approval	Physician	New OR
	Establish an outpatient surgical hospital Maryview Medical Center	Suffolk	Approval	Hospital	Relocation of ORs
	Establish an outpatient surgical hospital St. Mary's/Southside Regional M.C.	Chesterfield County	Approval	Hospital	Relocation of ORs
	Establish an outpatient surgical hospital Proctology Associates, Inc.	Chesapeake	Withdrawn	Physician	New ORs

Other In 1997, the Commissioner of Health offered a COPN to Chippenham Hospital/Johnston-Willis Medical Center to establish an outpatient surgical hospital in Chesterfield County if they agreed to certain conditions, including that the project reduce the number of ORs in PD 15. This applicant has not agreed to the conditions but has indicated that it still plans to accept the Commissioner's offer.

Also in 1997, the Commissioner offered a COPN to a joint venture consisting of Richmond Eye and Ear Hospital, Columbia/HCA, and MCV to establish an outpatient surgical hospital in Richmond as a replacement of the Richmond Eye and Ear Hospital, a 60 bed general hospital in Richmond. No new ORs would be created. This applicant has not agreed to the conditions as of this time.

APPENDIX G

VIRGINIA INDIGENT HEALTH CARE TRUST FUND

PRESENTATION MADE BY
THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1999 INTERIM STUDY

Virginia Indigent Health Care Trust Fund

The Virginia Indigent Health Care Trust Fund was created in 1989, as a public/private partnership between the Commonwealth and private acute care hospitals in the state in an effort to equalize the burden of charity care among the hospitals.

During 1990 the policies and procedures for operating the Fund were developed by the Technical Advisory Panel (TAP), the policy body guiding the Fund. The TAP consists of:

- the DMAS Director,
- the Commissioner of Health,
- the Commissioner of Insurance,
- the Chairman of the Virginia Health Care Foundation,
- 3 members of the Board of Medical Assistance Services including the chair,
- 2 representatives from the hospital industry,
- 3 representatives from the small business community,
- and a physician.

The primary purpose of the Fund is to reimburse hospitals for part of the cost of charity care, which is defined as hospital care for which no payment is received and which is provided to any person whose annual family income is equal to or less than 100 percent of the federal poverty level (in 1999, $16,700 for a family of four).

Hospital inpatient and outpatient medical services qualifying for reimbursements from the Fund are limited to those inpatient and outpatient services covered by the Medicaid program.

Total funding for the Virginia Indigent Health Care Trust Fund is $10 million annually. The funding is based on $6 million in General Funds and $4 million from contributing hospitals.

To operate the Fund each private acute care hospital is required to submit a Statement of Qualifying Charity Care annually to DMAS. DMAS receives the hospital financial data from Virginia Health Information.

Using the charity care and financial data DMAS establishes the contribution rate as a percent of profits so that the Trust Fund collects approximately $4 million from profitable hospitals after crediting their charity care costs and state corporate taxes.

The average contribution rate varies from year to year. The contribution rate in 1999 was 2.3% of profit. DMAS bills and collects from the hospitals.

Payments are made to hospitals based on the cost of charity care the hospital provided in excess of the median amount of charity care for all hospitals.

DMAS determines the percent so that the Trust Fund payments do not exceed the funding of $10 million. Due to the increasing level of charity care claimed compared to level funding of $10 million the percentage of charity care covered by the Fund has decreased from 60%, the maximum allowed, in 1991 to 42.46% for 1999.

You have a hand out listing hospitals contributing and receiving from the Trust Fund since 1993. Figures in brackets represent the contributions made by hospitals in each year. Figures without brackets represent payments to the hospitals. The dashes represent hospitals which neither contributed to or received payments from the Fund in that year.

In Fiscal Year 1999 hospital contributions ranged from a low of $1,426 to a high of $282,317. If a hospital has an operational loss the hospital does not make a payment even though the hospital may have not have had any charity care. In Fiscal Year 1999 payments to hospitals ranged from a low of $6,315 to a high of $1,397,319.

Commonwealth of Virginia		A Comparison of the Fiscal Year 1999 Results with those of Prior Years							
Department of Medical Assistance Services									
Virginia Indigent Health Care Trust Fund		FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	
		Net	Net	Net	Net	Net	Net	Net	
11/15/99		Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	
		(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	
FACILITY	HS	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	
==========	===	=========	=========	=========	=========	=========	==========	==========	
Augusta Medical Center	1	(134,489)	(90,870)	(169,710)	(109,600)	(90,317)	(159,810)	(79,208)	
Bath County Community Hospital	1	-	(2,740)	-	-	-	-	-	
Culpeper Memorial Hospital	1	13,758	6,965	(9,202)	(32,590)	(15,842)	(13,407)	93,787	
Fauquier Hospital	1	164,861	140,130	68,425	69,396	97,553	115,160	183,814	
Martha Jefferson Hospital	1	(46,685)	(48,036)	(46,996)	107,793	79,090	13,652	(69,991)	
Mary Washington Hospital	1	373,544	239,193	489,360	175,354	448,758	469,775	643,802	
Page Memorial Hospital	1	-	-	-	-	(30,959)	(25,915)	(28,259)	
Rockingham Memorial Hospital	1	(156,971)	(202,247)	(116,955)	(102,237)	(116,394)	(71,131)	(100,446)	
Shenandoah Memorial Hospital	1	3,918	(10,915)	32,182	56,355	140,451	122,794	208,413	
Stonewall Jackson Hospital	1	-	7,276	28,119	17,380	7,641	(11,354)	56,871	
Warren Memorial Hospital	1	29,831	29,198	24,071	54,927	39,946	5,016	(6,894)	
Winchester Medical Center	1	(167,395)	134,055	8,148	(60,172)	(149,872)	198,906	171,385	
		80,373	202,009	307,442	176,605	410,054	643,686	1,073,274	
Alexandria Hospital	2	1,016,697	1,009,104	585,408	634,849	775,906	444,458	855,028	
Arlington Hospital	2	635,023	581,350	449,861	777,420	1,050,867	511,127	855,761	
Fair Oaks Hospital (Inova)	2	(70,488)	(106,171)	(87,800)	(63,734)	(45,870)	(53,046)	(85,788)	
Fairfax Hospital (Inova)	2	1,053,452	(57,897)	691,363	1,115,718	642,861	1,160,979	878,996	
Jefferson Memorial	2	152,017	327,660	-	-	-	-	-	
Loudoun Hospital Center	2	61,573	16,675	41,061	(113,888)	(97,684)	(214,385)	-	
Mount Vernon Hospital	2	321,694	353,648	389,548	534,698	456,121	565,655	514,468	
National Hospital for Ortho. and Rehab	2	-	-	-	-	-	-	-	
Potomac Hospital	2	79,109	47,718	24,746	23,091	63,322	158,438	24,960	
Prince William Hospital Corporation	2	(2,953)	(70,797)	(123,040)	(157,072)	(144,274)	(133,710)	(143,639)	
Reston Hospital Center (Columbia)	2	(82,345)	(78,990)	(94,036)	(92,227)	(69,558)	(79,502)	(37,309)	
Vencor Hospital - Arlington	2	-	22,072	-	(17,017)	(26,201)	(54,774)	(54,233)	

Commonwealth of Virginia		A Comparison of the Fiscal Year 1999 Results with those of Prior Years							
Department of Medical Assistance Services									
Virginia Indigent Health Care Trust Fund		FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	
		Net	Net	Net	Net	Net	Net	Net	
11/15/99		Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	
		(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	
FACILITY	HS	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	
==========	===	=========	=========	=========	=========	=========	==========	==========	
Total HAS 2		3,163,780	2,044,372	1,877,111	2,641,838	2,605,490	2,305,241	2,808,244	
Alleghany Regional Hospital (Columbia	3	(19,589)	(33,567)	14,197	(33,804)	(72,177)	(36,685)	(4,941)	
Buchanan General Hospital	3	(13,412)	(40,854)	(29,075)	(73,146)	(84,359)	(61,986)	(10,759)	
Carilion Hospital Systems	3	735,288	1,306,021	1,194,376	521,848	672,418	973,420	(135,610)	
Centra Health	3	124,854	212,951	82,265	279,028	171,535	86,010	(52,003)	
Clinch Valley Medical Center (Columbi	3	(217,399)	(167,638)	(53,173)	(62,012)	(35,804)	(556)	(21,702)	
Danville Regional Medical Center	3	141,211	168,825	(42,491)	202,971	39,609	358,427	(186,655)	
Dickenson County Medical Center	3	-	(6,431)	-	(17,453)	145	54,587	-	
Johnston Memorial Hospital	3	(2,850)	1,806	(31,197)	58,072	33,598	(14,432)	(21,884)	
Lee County Community Hospital	3	24,983	(13,390)	56,878	38,800	82,246	113,562	150,865	
Lewis-Gale Medical Center (Columbia	3	(84,859)	(80,195)	(138,264)	(80,825)	(104,024)	(132,333)	(102,703)	
Memorial Hosptial of Martinsville & He	3	101,685	118,164	115,221	144,361	26,307	198,844	37,985	
Montgomery Regional Hospital (Colum	3	(14,117)	(6,755)	(39,497)	(64,053)	(79,882)	(35,515)	(52,530)	
Norton Community Hospital	3	(34,214)	228,786	(29,236)	-	(16,018)	(21,219)	(61,437)	
Patrick County Memorial Hospital	3	1,541	-	(1,761)	(2,004)	(5,126)	-	-	
Pulaski Community Hospital (Columbia	3	-	-	(11,114)	(24,906)	29,585	23,554	9,529	
Russell County Medical Center	3	(91,485)	(169,085)	(115,244)	(123,671)	(134,669)	(89,642)	(4,412)	
Smyth County Community Hospital	3	(41,521)	(28,864)	(25,190)	(42,256)	46,044	(57,684)	(28,406)	
St. Mary's Hospital (Norton)	3	24,030	10,783	(35,355)	(31,293)	(46,101)	(16,940)	35,409	
Tazewell Community Hospital	3	4,777	-	-	30,644	-	50,184	31,995	
Twin County Regional Hospital	3	107,405	131,863	74,766	106,630	136,508	203,790	217,107	
Wellmont Lonesome Pine Hospital	3	-	(636)	19,123	6,483	7,481	-	-	
Wise Appalachian Regional Hospital	3	12,494	8,484	-	-	-	-		
Wythe County Community Hospital	3	91,807	88,095	72,425	54,812	43,379	46,623	78,135	
Total HAS 3		850,627	1,728,363	1,077,654	888,221	710,694	1,642,008	(122,017)	

Commonwealth of Virginia		A Comparison of the Fiscal Year 1999 Results with those of Prior Years							
Department of Medical Assistance Services									
Virginia Indigent Health Care Trust Fund		FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	
		Net	Net	Net	Net	Net	Net	Net	
11/15/99		Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	
		(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	
FACILITY	HS	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	
==========	===	=========	=========	=========	=========	=========	==========	==========	
Capital Hospital	4	(10,496)	(28,380)	(23,568)	16,487	19,245	(23,081)	(29,027)	
Children's Hospital	4	222,826	77,180	-	-	-	-	-	
Chippenham & Johnston-Willis Hospita	4	(313,492)	(259,589)	(399,983)	(339,258)	(227,236)	(279,084)	(187,723)	
Community Memorial Healthcenter	4	182,155	295,013	209,633	179,976	249,617	269,470	287,798	
Greensville Memorial Hospital	4	92,931	119,391	78,025	22,443	(2,169)	(5,496)	6,315	
Halifax Regional Hospital	4	19,303	16,152	(7,573)	77,040	89,526	(1,058)	(47,980)	
Healthsouth Medical Center - Richmon	4	-	-	(21,510)	(18,616)	-	(78,961)	(32,355)	
Henrico Doctors' Hospital (Columbia)	4	(261,070)	(351,853)	(348,888)	(245,396)	(295,223)	(246,585)	(134,527)	
John Randolph Hospital (Columbia)	4	-	(14,532)	(33,934)	(14,838)	(12,277)	(36,752)	-	
Retreat Hospital (Columbia)	4	(48,240)	(2,659)	-	-	-	-	-	
Richmond Community Hospital (Bon S	4	5,318	-	(8,880)	-	-	(12,144)	(9,267)	
Richmond Eye and Ear Hospital	4	-	(14,071)	(1,726)	(8,383)	(1,215)	-	(2,519)	
Richmond Memorial Hospital	4	(68,854)	(46,298)	(59,203)	(31,031)	(64,732)	-	(44,248)	
Southside Community Hospital	4	78,945	17,264	68,482	44,120	108,907	111,977	185,893	
Southside Regional Medical Center	4	82,745	271,554	39,837	6,691	188,252	137,251	168,654	
St. Mary's Hospital (Richmond)	4	(183,749)	(176,084)	(153,161)	(202,808)	(264,644)	(275,587)	(282,317)	
Stuart Circle Hospital (Bon Secours)	4	-	-	-	(64,110)	(30,944)	(34,781)	(18,738)	
		(201,678)	(96,912)	(662,449)	(577,685)	(242,895)	(474,832)	(140,041)	
Bayside Hospital (Sentara)	5	(60,166)	-	(43,909)	(25,951)	-	(58,719)	(45,185)	
Chesapeake General Hospital	5	(102,142)	(142,301)	(136,298)	(35,216)	(121,350)	(240,928)	(243,390)	
Children's Hospital of the King's Daugh	5	(70,369)	(89,421)	(118,384)	(68,275)	(304)	(83,316)	(93,152)	
DePaul Medical Center	5	589,985	668,691	521,166	504,228	584,494	596,855	721,879	
Hampton General Hospital (Sentara)	5	91,247	144,096	148,569	216,650	7,515	90,203	170,468	

Commonwealth of Virginia		A Comparison of the Fiscal Year 1999 Results with those of Prior Years							
Department of Medical Assistance Services									
Virginia Indigent Health Care Trust Fund		FY 1993	FY 1994	FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	
		Net	Net	Net	Net	Net	Net	Net	
11/15/99		Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	Payment to	
		(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	(Rec'd from)	
FACILITY	HS	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	Hospitals	
Leigh Hospital (Sentara)	5	(66,892)	(110,836)	(133,733)	(138,856)	(120,948)	(204,726)	(214,680)	
Louise Obici Memorial Hospital	5	154,038	-	66,790	204,173	68,595	(34,153)	131,853	
Mary Immaculate Hospital	5	(58,991)	-	-	-	(33,375)	(53,756)	(37,516)	
Maryview Medical Center (Bon Secour	5	145,973	421,927	365,870	438,429	344,985	6,244	(1,426)	
Newport News General Hospital	5	141,157	110,900	81,966	42,635	38,438	-	-	
Norfolk Community Hospital	5	45,501	-	-	(6,892)	(5,580)	(71,673)	-	
Norfolk General Hospital (Sentara)	5	1,110,898	1,113,339	2,329,308	1,789,207	1,361,783	1,046,897	1,397,319	
Portsmouth General Hospital (Bon Sec	5	206,000	303,226	270,946	284,590	298,121	492,662	240,336	
Rappahannock General Hospital	5	(3,413)	5,594	(10,057)	(4,169)	(6,723)	(10,629)	15,631	
Riverside Regional Medical Center	5	(202,640)	(258,356)	(202,893)	(365,543)	58,774	291,976	(273,254)	
Riverside Tappahannock Hospital	5	-	(1,022)	(10,019)	(38,994)	(55,399)	(32,494)	(37,293)	
Riverside Walter Reed Hospital	5	(41,926)	(21,240)	18,823	53,820	29,296	(12,198)	(32,247)	
Shore Memorial Hospital	5	182,997	169,587	72,599	142,529	84,616	150,311	294,400	
Southampton Memorial Hospital	5	477	3,248	177,441	36,026	101,118	97,545	60,712	
Virginia Beach General Hospital	5	(128,555)	(109,077)	163,473	(23,724)	(82,046)	39,342	396,292	
Williamsburg Community Hospital	5	(64,400)	(98,071)	(165,155)	(135,146)	(36,573)	(126,181)	(71,005)	
Rounding Differences	5	-	-	-	-	-	1	(4)	
Total HAS 5		1,868,780	2,110,284	3,396,503	2,869,521	2,515,438	1,883,262	2,379,738	
General Funds		5,761,882	5,988,116	5,996,261	5,998,499	5,998,781	5,999,366	5,999,198	

APPENDIX H

POWERPOINT PRESENTATION
FIFTY-STATE TELEPHONE SURVEY
DIVISION OF LEGISLATIVE SERVICES

CERTIFICATE OF NEED AND OTHER HEALTH POLICY QUESTIONS: 1999 FIFTY- STATE TELEPHONE SURVEY

INTRODUCTION

A fifty-state telephone survey was conducted in October and November of 1999. In states having CON programs, each state respondent was asked to identify CON-regulated facilities/services/equipment, and expenditure thresholds. When relevant, each respondent was asked to make observations concerning CON deregulation or phase-out. All respondents were asked to make observations about current trends in health care, the effects of any changes in health policy or any influences on the health care industry which may be currently occurring. All fifty states were contacted; forty-nine states' responses are used in this analysis; Vermont's data is taken from the 1999 edition of the National Directory of Health Planning, Policy and Regulatory Agencies published by the American Health Planning Association.

Certificate of Need Law Comparison: 1995 and 1999

1995

In 1995, thirty-nine (39) states had CON laws, i.e., Alabama Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

One (1) state, i.e., Louisiana, maintained a § 1122 review process for determining facility need for Medicaid services only. Louisiana has never had a certificate of need law.

Ten (10) states had either repealed their CON laws or allowed their CON laws to expire, i.e., Arizona, California, Colorado, Idaho, Kansas, New Mexico, South Dakota, Texas, Utah, and Wyoming.

Certificate of Need Law Comparison: 1995 and 1999

1999

In 1999, thirty-five (35) states have CON laws of some kind, i.e., Alabama, Alaska, Arkansas, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

One (1) state, i.e., Louisiana, continues to maintain a § 1122 review process for determining facility need for Medicaid services only.

Fourteen (14) states have either repealed their CON laws or allowed their CON laws to expire, i.e., Arizona, California, Colorado, Idaho, *Indiana, Kansas, *Minnesota, New Mexico, *North Dakota, *Pennsylvania, South Dakota, Texas, Utah, and Wyoming.

STATES FOCUSING ON LONG-TERM CARE COVERAGE

Seven states have CON programs which concentrate on review of long-term care facilities, beds, or services. These states are:

Arkansas
Montana
Nebraska
Ohio
Oklahoma
Oregon
Wisconsin

STATES WITH OTHER KINDS OF LIMITED CON COVERAGE

Four states have other types of limited CON laws, i.e., Maryland, New Jersey, Florida, and Nevada.

One state, Maryland, is the only state with both a rate-setting commission and a certificate of need program. In 1986, Maryland established an exemption for ambulatory surgery centers having no more than four operating rooms, if the facility is used by a single group with a single specialty. In 1995, a second exemption was provided for single operating room ambulatory surgery centers, regardless of the number of groups or specialties practicing in the facility. Also in 1995, Maryland's CON coverage of hospitals was reduced to hospital closures and mergers. Maryland does not regulate major medical equipment purchases; however, home health, hospice, and ICF for adolescents are covered.

STATES WITH OTHER KINDS OF LIMITED CON COVERAGE

Nevada's CON program receives approximately two applications a year. Equipment was deregulated in 1995. Currently, the program covers only new construction costing over $2 million. The program does not cover expenditures which are not directly related to providing health services. Further, the two most populous counties of the seventeen counties are exempted from CON, i.e., Clark County which includes Las Vegas and about 60 percent of Nevada's population and Washoe County which includes Reno and approximately 15 percent of Nevada's population. Thus, Nevada's CON program has a limited rural focus, covering the 15 sparsely populated rural counties.

STATES WITH OTHER KINDS OF LIMITED CON COVERAGE

New Jersey is in the process of a three-stage phase out of its CON program. On June 30, 1998, the first phase of the process was begun, i.e., additional services in existing facilities are exempted; CT scanners and MRI's were deregulated; ambulatory surgery centers are currently receiving minimal reviews. Various projects are set to expire on March 1, 2000, including ambulatory surgery centers, lithotripsy, obstetrical care, PET scanners, and radiation therapy. The third phase of the deregulation process will be implemented in the coming year pursuant to the recommendations of a study commission which has been charged with determining if the CON program should be continued at all.

STATES WITH OTHER KINDS OF LIMITED CON COVERAGE

Florida's CON program was amended significantly in 1997. The Florida CON program does not require CON for ambulatory surgery centers, does not cover equipment purchases, and does not have any capital expenditure threshold. The Florida CON program does cover the addition of inpatient hospital and nursing home beds and facilities, new open heart units, and the conversion of acute beds to SNF beds. New burn care units, neonatal special care, organ transplant services, psychiatric services, and substance abuse services are also reviewed.

STATE MORATORIUMS

A number of states have moratoriums on services, as follows:

Minnesota—hospital and nursing home beds
Mississippi—home health agencies (no new since 1983)
Missouri—residential care facilities
Montana—home health agencies
Nebraska—hospitals (expired on June 13, 1999)
Ohio—nursing home beds (new)
Utah—Medicaid nursing homes
Wisconsin—nursing home beds
Wyoming—long-term care beds

In addition, Georgia has accepted no nursing home applications in the last two years. Further, West Virginia does not approve personal care services applications, if the service will increase the state budget; personal care services are funded by Medicaid.

COMMENTS: STATES WITHOUT CON PROGRAMS

Arizona's CON program was repealed in 1986. The state respondent observed a nursing home building spree immediately after repeal and an increase in tertiary/high tech services in hospitals. These service increases appear to have contributed to an increase in rates. The influx of managed care and the new PPS have caused some reductions in services, particularly in emergency services and restorative therapies.

California's CON program was repealed on January 1, 1987, pursuant to a delayed effective bill which was passed in 1985. The state respondent noted that California has not tried to evaluate or reconstruct the effects of the CON repeal. Hospitals and ambulatory surgery centers were not considered to have problems. Over building in the nursing home industry was noted. California requires nonprofit hospitals to report charity care to justify their nonprofit status.

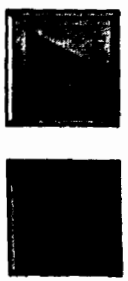
COMMENTS: STATES WITHOUT CON PROGRAMS

Colorado's CON law was repealed in 1987. Some hospital closings have been noted and attributed to financial problems. Managed care is pervasive. There has been tremendous growth in ambulatory surgery centers in Colorado and hospitals are moving in this direction as well. Some hospitals have joint ventures with physicians for ambulatory surgery centers. The market in Colorado was said to be receptive to innovative ambulatory care and alternative treatments.

Idaho's CON program was repealed in 1995 (approximately). The respondent noted that no formal evaluation was conducted of the effects of CON repeal. The new PPS was noted as having dramatic effects on home health services and perhaps on hospitals. This impact is generating interest in the critical access hospital designation.

COMMENTS: STATES WITHOUT CON PROGRAMS

Indiana's CON nursing home coverage expired on July 1, 1998. The nursing home industry overbuilt in the 1980s, with low occupancies still a problem, i.e., a few as low as 50 percent this year. Forty facilities have closed in the last year. Assisted living facilities, which are not even licensed in Indiana, are increasing quickly. These facilities are now required to register. Hospitals have remained stable (132). Larger urban hospitals seem to be buying smaller rural hospitals. Indiana is seeing the development of hospitals within hospitals, i.e., units for rehab or chronically ill patients.



Kansas' CON program was repealed in 1985. Kansas saw approximately a 10 percent increase in nursing home beds thereafter. Five or six new psych hospitals were built in the 1980s. Some are already out of business. The new PPS was noted as causing closings of home health agencies. In primarily rural Kansas, these closings are concerning and the agency has recently started to track them.

COMMENTS: STATES WITHOUT CON PROGRAMS

Minnesota's CON program expired on June 30, 1984. Moratoriums were put in place on both hospitals and nursing homes. The state respondent noted an increase in ambulatory surgery centers, especially recently, and a boom in assisted living facilities. At least two hospitals are converting to critical access hospitals. The moratoriums do have general exceptions, such as health and safety, replacements, cost neutral additions (no Medicaid), etc.

New Mexico's CON program was repealed in 1985. The respondent noted that New Mexico is so very rural that the health care industry is small and not really growing. In some jurisdictions, hospitals are 200 or more miles apart. Managed care was described as having a straggle hold on the industry. Almost all of the managed care companies are aligned with a hospital; most doctors are aligned with one of the managed care companies.

COMMENTS: STATES WITHOUT CON PROGRAMS

North Dakota's CON law was repealed on August 1, 1995. Increases in construction were experienced. Two hospitals have closed. North Dakota's total population is only 630,000. Health care costs are increasing. The Blues have just recently announced a 19 percent increase in premiums for the state employees benefit plan; last year's increase was 12 percent. The increased new construction and the almost total lack of managed care have contributed to these increases. North Dakota appears to have (anecdote) experienced some increases in ambulatory service centers.

Pennsylvania's CON program expired on December 17, 1996. The state respondent had no comment on changes occurring since that expiration.

COMMENTS: STATES WITHOUT CON PROGRAMS

South Dakota's CON Program was repealed in 1988. The respondent noted south Dakota's small population, i.e., approximately 700,000. The respondent noted that ambulatory surgery centers in South Dakota were transforming into specialty hospitals. Specialty hospitals apparently are "cherry picking" the paying patients who are in the best health. South Dakota has a small health care industry (56 hospitals in all, with 7 specialty hospitals in urban areas).

Texas's CON program was repealed in 1985. The respondent was reluctant to attribute any changes in the health care industry to the repeal. Texas is growing and apparently revising its public health services; the state has a huge long-term care industry. Although no data or general observations were provided, the respondent did note the scores of issues experienced by the teaching hospitals. Another states' respondent stated that Texas's home health industry is suffering, with many closings over the past few months.

COMMENTS: STATES WITHOUT CON PROGRAMS

Utah's CON program sunsetted in 1985. Utah has a regulatory Medicaid nursing home moratorium because of unbridled growth in the industry. The moratorium only addresses additional facilities. Both psych hospitals and nursing homes have experienced problems because of an influx of services. Nursing home occupancies are down, approximately 76 percent in October. Part of the nursing home problems may be attributable to gther growth in community and home-based care. Assisted living facilities have had "huge" growth in the last five years.

Wyoming's CON program was repealed in 1986. Wyoming has a population of 480,000 people; one managed care group covering 10,000 people; no Medicaid managed care; 25 hospitals; and two for-profit hospitals The state respondent stated that all tertiary care goes out of state to Denver or some other large city. Wyoming can't get facilities to come into the state. Between 3 to 10 of the existing hospitals could be interested in critical access status.

FIFTY-STATE SURVEY

SUMMARY

Among the states without CON programs, excess capacity in nursing home beds was mentioned by five states (Arizona, California, Indiana, Kansas, Utah). Hospital issues were mentioned by five states (Arizona, Minnesota, North Dakota, South Dakota, and Texas). Rural health issues, such as home health closings, were mentioned by seven states (Idaho, Indiana, Kansas, New Mexico, North Dakota, South Dakota, and Wyoming). Increases in ambulatory surgery centers were mentioned by three states (Minnesota, North Dakota, and South Dakota). Increases in assisted living facilities were mentioned by three states (Indiana, Minnesota, and Utah).