Agenda

March 8, 2024 at 9:00 a.m.
Board Room 4, Perimeter Center
9960 Mayland Drive, Henrico, VA 23233

1. Call to Order and Welcome – Dr. Thomas Eppes, Jr., Chair
2. Review of Agenda – Rebekah E. Allen, Senior Policy Analyst, Office of Licensure and Certification
3. Staff Presentation: COPN Program

Break (until 10:00AM)

4. Roll Call – Dr. Eppes
5. Approval of Prior Meeting Minutes
6. Public Comment Period
7. Psychiatric Beds and Services & Expedited Review
    a. Staff Presentation
    b. Breakout Session*

Break

    c. Group Discussion
8. Wrap-Up and Next Steps
9. Meeting Adjournment

* The Task Force will form into three smaller groups for the breakout session; the breakout session are open to the public and the discussion of each group will be included in the meeting minutes.

VDH VIRGINIA DEPARTMENT OF HEALTH

Certificate of Public Need

Applicability, Projects & Application Processes

1

Applicability

2

Who needs to obtain a COPN?

- Hospitals licensed by VDH
- Hospitals licensed by DBHDS
- Nursing homes
- Intermediate care facilities for individuals with intellectual disabilities that have more than 12 beds
- Intermediate care facilities for individuals with substance abuse
- Specialized centers/clinics or portion of physician offices providing:
  - Outpatient or ambulatory surgery;
  - Cardiac catheterization;
  - CT scanning;
  - MRI;
  - PET scanning;
  - radiation therapy;
  - Stereotactic radiotherapy—not performed using a linear accelerator or equipment using concentrated high-energy X-ray doses—to perform external beam radiation therapy; or
  - Proton beam therapy

3

Projects, Expenditures & Equipment

4

What activities are subject to standard review?

- Establishing a medical care facility
- Increasing total number of beds or operating rooms
- Relocating beds from an existing medical care facility to another
- Addition of new nursing home service
- Converting beds in an existing medical care facility to medical rehabilitation or psychiatric beds
- Converting psychiatric beds approved pursuant to an RFA to nonpsychiatric beds

5

What activities are subject to standard review?

- If not provided in the prior 12 months, introducing services for:
  - Cardiac catheterization;
  - CT scanning;
  - MRI
  - Medical rehabilitation;
  - Neonatal special care;
  - Open heart surgery;
  - PET scanning;
  - Psychiatric service;
  - Organ or tissue transplant service;
  - Radiation therapy;
  - Stereotactic radiotherapy—not performed using a linear accelerator or equipment using concentrated high-energy X-ray doses—to perform external beam radiation therapy;
  - Proton beam therapy; or
  - Substance abuse treatment
- Addition of new equipment for:
  - Cardiac catheterization;
  - CT scanning;
  - MRI
  - Open heart surgery;
  - PET scanning;
  - Radiation therapy;
  - Stereotactic radiotherapy—not performed using a linear accelerator or equipment using concentrated high-energy X-ray doses—to perform external beam radiation therapy; or
  - Proton beam therapy

6

What activities are subject to expedited review?

- Capital expenditure of $15 million or more by or on behalf of medical care facility other than a general hospital

7

What activities are subject to registration?

- Acquisition of equipment for:
  - Cardiac catheterization;
  - CT scanning;
  - Stereotactic radiosurgery;
  - Stereotactic radiotherapy performed using a linear accelerator or other equipment that uses concentrated high-energy X-ray doses to perform external beam radiation therapy;
  - Lithotripsy;
  - MRI
  - MSI
  - Open heart surgery;
  - PET scanning;
  - Radiation therapy;
  - Proton beam therapy; or
  - Nuclear imaging services
- If not provided in the prior 12 months, introducing services for:
  - Lithotripsy;
  - Stereotactic radiosurgery;
  - Stereotactic radiotherapy performed using a linear accelerator or other equipment that uses concentrated high-energy X-ray doses to perform external beam radiation therapy;
  - Obstetrical; or
  - Nuclear imaging services

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What activities are subject to registration?

- Replacement of equipment for:
  - Cardiac catheterization;
  - CT scanning;
  - MRI;
  - Open heart surgery;
  - PET scanning;
  - Radiation therapy;
  - Stereotactic radiotherapy—not performed using a linear accelerator or equipment using concentrated high-energy X-ray doses—to perform external beam radiation therapy;* or
  - Proton beam therapy
- Capital expenditure of $5 million or more by or on behalf of a general hospital
- Capital expenditure between $5 million and $15 million by or on behalf of medical care facility other than a general hospital

* There is a conflict in the Code of Virginia wherein § 32.1-102.1:2(B) requires registration and 32.1-102.2(D) exempts this from registration. The State Board of Health has approved a regulatory action (currently under executive branch review) to clarify that registration is not required.

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Application Processes

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Registration

The State Board of Health is currently amending its regulations to update registration to include expanded registration eligibility.

- Replacement equipment:
  - Must register in writing with the Commissioner and, if applicable, RHPA
  - At least 30 days before contracting or obligating to make a capital expenditure for replacement
  - Form must specify unit of equipment and estimated capital cost
  - Include documentation that the equipment to be replaced has previously been authorized or exempted as allowed by law.
- Capital expenditures:
  - Must register in writing with the Commissioner and, if applicable, RHPA
  - At least 30 days before contracting or obligating to make a capital expenditure
  - Must specify expenditure's purpose and projected impact it will have on charges for services

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Standard Review – Batch Cycle

Batch Group	General Description	Cycle Begins	Cycle Ends
A	General Hospitals/Neonatal Special Care Services	Feb. 10 Aug. 10	Aug. 18 Feb. 16
B	Open Heart Surgery/Cardiac Catheterization/Ambulatory Surgery Centers/Operating Room Additions/Transplant Services	Mar. 10 Sep. 10	Sep. 16 Mar. 19
C	Psychiatric Facilities/Substance Abuse Treatment	Apr. 10 Oct. 10	Oct. 17 Apr. 18
D	Diagnostic Imaging Facilities/Services	May 10 Nov. 10	Nov. 16 May 19
E	Medical Rehabilitation Beds/Services	June 10 Dec. 10	Dec. 17 Jun. 18
F/D	Selected Therapeutic Facilities/Services Diagnostic Imaging Facilities/Services	July 10 Jan. 10	Jan. 16 Jul. 18
G	Nursing Homes/Intermediate Care Facilities for Individuals with Intellectual Disabilities	Jan. 10 Mar. 10 May 10 July 10 Sep. 10 Nov. 10	Jul. 18 Sep. 16 Nov. 16 Jan. 16 Mar. 19 May 19

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Standard Review – Prior to Batch Cyle Start

- Applicant files LOI by the later of:
  - 30 days prior to application submission for a particular batch group; or
  - 10 days after the first LOI is filed for a particular batch group for same/similar services and facilities in the same PD
- LOI must identify:
  - Project owner;
  - Project type;
  - Proposed project scope/size; and
  - Location of the proposed project.
- LOI is void one year after the date of receipt
- VDH posts LOIs to its website

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Standard Review – Application Receipt & Review

- Applications are complete if there is a satisfactory answer to every applicable question
- VDH notifies applicant:
  - If its application is accepted
  - Of review schedule and date for potential informal fact-finding conference (IFFC)
  - Applicant if there are competing applications
- VDH posts application to its website
- RHPA's review and recommendation due by 60th day of batch cycle
  - RHPA has to transmit the recommendation to VDH within 10 calendar days
- VDH's review and recommendation due by 70th day of batch cycle
- VDH notifies applicant whether IFFC is necessary by 75th day of batch cycle

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Standard Review – Public Participation

- VDH or RPHA, if applicable, solicits public comment by 10th day of batch cycle
  - Public comment period cannot be greater than 45 calendar days
- VDH or RPHA, if applicable, holds a public hearing:
  - In the case of competing applications; or
  - In response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public
- VDH or RPHA, if applicable, must notify PD's local governing bodies prior to public hearing
- VDH or RPHA, if applicable, publishes newspaper notice at least 9 days prior to the public hearing
- RPHA cannot hold more than 2 meetings on any application (inclusive of public hearing)

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Standard Review – Informal Fact-Finding Conference

- IFFC required if:
  - Deemed necessary by VDH; or
  - Requested by a person seeking to be made a party to the case for good cause
- IFFC occurs between 80th and 90th day of batch cycle
- If there is no IFFC, record closes on earlier of the date:
  - IFFC would've been held; or
  - VDH determines IFFC is not necessary
- If there is an IFFC, record closes no more than 30 days after IFFC (110th to 120th day of batch cycle)
- Adjudication officer (VDH employee) presides at IFFC and makes recommendation after record closes
  - Adjudication officer functions must be separate from project review functions

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Standard Review – Commissioner's Determination

- Commissioner has sole discretion in determining whether public need exists
- Within 45 days of record closing (155th to 165th day of batch cycle), Commissioner:
  - Approves the application;
  - Denies the application; or
  - Invokes a 25-day extension
- If Commissioner invokes the 25-day extension and does not make a decision at the end of that period (180th to 190th day), the application is deemed approved

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Expedited Review

- Applications may be filed at any time
  - There is no batching under expedited review
  - No LOI requirement
- Applications are complete if there is a satisfactory answer to every applicable question
- Any person directly affected by project may submit written opinions, data and other information to VDH and RPHA, if applicable
- VDH and RPHA, if applicable, review and recommendation due by 40th day after receipt of application
- Commissioner's determination due by 45th day after receipt of application
- Projects ineligible for expedited review redirected to standard review, but are exempt from LOI requirement

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Criteria for Review

- The same criteria is used for standard review and expedited review
- Decision to issue a COPN must be consistent with the SHSP's most recent applicable provisions
  - If the Commissioner finds the SHSP' provisions are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner may issue a COPN and initiate procedures to make appropriate amendments to SHSP
- There are eight statutory considerations that the Commissioner must make when reviewing an application (§ 32.1-102.3(B)

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Conditions for Projects

- Projects under standard review and expedited review are subject to conditioning
- Discretionary conditions:
  - Schedule for the completion of the proposed project; and
  - Maximum capital expenditure amount for the proposed project
- Mandatory conditions:
  - Provide care to individuals who are eligible for benefits under Medicare, Medicaid, and TRICARE; and
  - One of the following:
    - Provide a specified level of charity care to indigent persons or accept patients requiring specialized care;
    - Facilitate development and operation of primary and specialty medical care services in designated MUAs of the applicant's service area;
    - Both
- Appropriations Act exempts nursing homes from mandatory conditions
- Utilization data and charity care data required to be reported

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Registration Changes

- Currently, there is *NO* conditioning of registrations
- Regulations to be promulgated for certain equipment and service registration to implement 2020 changes that include:
  - Establishing applicant's agreement to provide a level of care in services or funds that matches the average percentage of indigent care provided in HPR and to participate in Medicaid at a reduced rate to indigents;
  - Obtaining accreditation from a nationally recognized accrediting organization approved by the Board;
  - Reporting utilization and other data required by the Board
- Utilization data required to be reported

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Questions?

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State Health Services Plan Task Force
February 9th, 2024
Time 9:00 a.m.
Perimeter Center, Board Room 3
9960 Mayland Drive
Henrico, VA 23233

Task Force Members in Attendance – Entire Meeting (alphabetical by last name): Jeannie Adams; Kathy Baker; Dr. Keith E. Berger; Karen Cameron; Carrie Davis; Michael Desjadon; Paul Dreyer; Kyle Elliott; Dr. Thomas Eppes, Jr.; Paul Hedrick; Shaila Camile Menees; Tom Orsini.

Task Force Members in Attendance – Partial Meeting (alphabetical by last name): Rufus Phillips.

Staff in Attendance (alphabetical by last name): – Rebekah E. Allen, Senior Policy Analyst, Virginia Department of Health (VDH) Office of Licensure and Certification (OLC); Kimberly F. Beazley, Director, VDH OLC; Erik O. Bodin, COPN Director, VDH OLC; Allyson Flinn, Policy Analyst, VDH OLC; Joseph Hilbert, Deputy Commissioner of Governmental and Regulatory Affairs, VDH; Val Hornsby, Policy Analyst, VDH OLC; R. Christopher Lindsay, Chief Operating Officer, VDH; Dr. Karen Shelton, State Health Commissioner, VDH.

1. **Call to Order and Introductions**

   Dr. Karen Shelton called the meeting to order at 9:08 a.m. by providing opening comments about the charge of the Task Force and leading the introduction of the Task Force members.

2. **Review of Agenda**

   Rebekah E. Allen reviewed the agenda.

3. **Public Comment Period**

   No Task Force members or members of the public signed up to give public comment, and no public comments were received.

4. **Adoption of Bylaws**

   Ms. Allen reviewed the draft Bylaws with the Task Force. The Bylaws were moved by Karen Cameron and seconded by Michael Desjadon. The Task Force unanimously adopted the draft Bylaws by voice-vote.

5. **Election of the State Health Services Task Force Chair and Vice Chair**

   Ms. Allen reviewed the requirement for the Task Force to elect a Chair and Vice Chair and asked the group for its nominations. Dr. Keith Berger nominated Dr. Thomas Eppes for Task Force Chair and seconded by Carrie Davis. The Task Force unanimously elected Dr. Eppes by voice-vote.

Ms. Cameron was nominated for Vice Chair by Rebecca Butler. The Task Force unanimously elected Ms. Cameron by voice-vote.

6. Adoption of the Remote Participation Policy

Ms. Allen reviewed the draft Remote Participation Policy with the Task Force. There was discussion regarding the distance required by the policy between a meeting and a member's primary residence and whether the meeting technology available to the Task Force will allow Task Force members joining virtually to be seen and heard by the group.

Mr. Desjadon moved to adopt the draft Remote Participation Policy with Jeannie Adams seconding that motion. The Task Force unanimously adopted the Remote Participation Policy by voice-vote.

7. Discussion

The discussion portion of the meeting was led by Dr. Eppes, who expressed the need for the Task Force to schedule at least 3 meetings between now and October 1, 2024. Ms. Cameron requested that the VDH provide data regarding Certificate of Public Need (COPN) applications in recent years to posture the Task Force to what COPN looks like in Virginia.

Mr. Desjadon discussed the content that the Task Force may want to focus on for upcoming meetings, suggesting one meeting focus on psychiatric services and the next focus on expedited review.

Carrie Davis requested location data regarding COPN requests from VDH for the next meeting to see where projects have occurred. Tom Orsini requested VDH also provide some kind of information or training regarding expedited review and how that process currently works in Virginia. Ms. Cameron then requested additional data visualizations from VDH to show the COPN processes to which projects are subject.

Erik Bodin explained the expedited review process and clarified with the Task Force that VDH has not received a request for an expedited project in a long time because so few projects meet the current statutory criteria for expedited review. Mr. Bodin also suggested the Task Force consider for its recommendations "triggers" that will take a project out of expedited review and into full review if a project becomes contested. Mr. Bodin further explained the differences between the expedited process and the full review process. Ms. Adams inquired with Mr. Bodin whether the Task Force will be making recommendations on the process of expedited review, to which Mr. Bodin answered that the Task Force is directed to make those recommendations by the Code of Virginia. Ms. Allen then clarified that project types for expedited review are limited to capital expenditures over $15 million, as adjusted for inflation, taken by or on behalf of facilities that are not a general hospital.

Ms. Cameron requested VDH create a color-coded map detailing the different batching cycles by location and the results of those projects. Ms. Cameron clarified that this will allow the Task Force to consider geography when creating their mandated recommendations. Dr. Eppes asked VDH how long they expected this to take to which Ms. Allen responded one month. Kathy Baker then requested VDH provide the Task Force with the specific goals and metrics of the State Health Improvement Plan that the Task Force will need to consider when creating recommendations.

Ms. Cameron suggested to the Task Force that they could consider hosting the meeting at different locations in the area if VDH was unable to secure a room at the Perimeter Center on the date the Task Force has planned to meet.

Ms. Allen offered the Task Force data regarding the COPN process in other states, with specific focus on how these states handle expedited review and psychiatric services.

Shaila Menees requested that VDH create a data sharing process for Task Force members to access documents.

Dr. Eppes reviewed the meeting schedule with the Task Force and asked that their next meeting be scheduled for March 8th. The Task Force agreed that Fridays are best for everyone's schedules, as well as mornings. Dr. Eppes asked that the first half of the March 8th meeting be focused on educating the Task Force about the standard COPN process and expedited review process.

Dr. Berger requested an overview of the COPN process, to which Mr. Bodin gave a high-level explanation of how this process currently works. Dr. Eppes then requested that VDH supply the Task Force with documents on how the COPN process works for the March 8th meeting. Dr. Eppes recommended the third Task Force meeting of the year be held on May 17th. Dr. Eppes acknowledged that the summer months may be challenging for scheduling a meeting and recommended the fourth meeting be held on September 6th. Dr. Eppes then suggested that the Task Force plan an all-virtual meeting over the summer in order to ensure all business is handled.

Ms. Cameron requested that VDH create a roster of the Task Force members to include their names and contact information. Ms. Allen then reviewed the list of requested deliverables from the Task Force. Dr. Eppes requested that the Task Force members create a paragraph regarding their biases and where they stand on the COPN process before the next meeting. Ms. Davis requested VDH supply the Task Force with the batch group timelines for review. Mr. Desjadon then requested that VDH create a list of all current COPN applications for the Task Force to see what projects are currently in process. Ms. Menees then requested that the Task Force members provide information regarding their current experience with the COPN process in Virginia or another state.

Mr. Desjadon discussed the potential conflict of interest that may stem from Ms. Cameron's earlier suggestion to hold meeting at different stakeholder buildings in the area and asked the Task Force to reconsider holding the meetings at stakeholder buildings. Ms. Cameron clarified with the Task Force that the members cannot meet in groups larger than 3 members to discuss Task Force-related work.

Ms. Cameron asked the Task Force what the group would like to focus on for the upcoming meetings. Dr. Eppes requested the Task Force focus on psychiatric services and what other states do first, and then focus more on expedited review during later meetings. Ms. Menees reminded the Task Force that there are certain mandated considerations for the Task Force, and that it would be prudent to focus on those mandates. Mr. Desjadon suggested the Task Force focus on creating an ABC approach to recommendations, starting with the recommendations that already exist, then recommendations that have been considered, and finally recommendations that have not yet been considered.

Dr. Eppes requested that the next meeting have time scheduled where the Task Force members are split into groups of 5 to discuss potential recommendations. Joe Hilbert reminded the Task Force that this activity would need to be posted on the agenda to ensure the Task Force did not violate the Freedom of Information Act (FOIA). Ms. Cameron inquired about how the split group idea would work with virtual members, to which Ms. Allen responded that she would need to investigate the inquiry further to ensure compliance with FOIA.

Ms. Menees inquired about the possibility of VDH hosting office hours throughout the month for the Task Force members to attend in order to ask questions prior to the March 8th meeting. Ms. Cameron reminded the Task Force that no more than 3 members would be able to attend the office hours at a time, and that the virtual meeting requirements are either 2 meetings per year or 25% of the Task Forces meetings. Ms. Adams expressed concern over the office hours, stating that all members should hear the education and guidance provided by VDH staff.

In lieu of office hours, Ms. Cameron suggested the Task Force plan for a long meeting on March 8th to cover all the material planned for that date. Mr. Desjadon also suggested that the group collect their questions for VDH prior to the meeting to ensure all questions are answered and that VDH staff have prepared answers to ensure the meeting be as efficient as possible. Ms. Davis requested the March 8th meeting be held in 2 parts, with one session in the morning and the next in the afternoon after a break for lunch. Dr. Eppes concurred with Ms. Davis.

Dr. Eppes requested the March 8th meeting be held at 9 am to cover all educational material requested from VDH. Mr. Dreyer reminded the Task Force that there are many topics that the Task Force will need to make recommendations on, and that the members will need to be mindful of this as they move forward in the planning process. Ms. Cameron requested the members think about services that may not be appropriate for expedited review due to controversy. Ms. Menees suggested that the Task Force create a schedule of topics to discuss for future meetings by the end of the March 8th meeting.

8. Meeting Adjournment

The meeting adjourned at 10:34 a.m.

Psychiatric Facilities and Services

1

Senate Bill 277 (2024)

- Update – currently pending a vote on the House floor
- Develop recommendations for the following relating to expedited review:
  - What facilities and project types should be added
  - Criteria that should apply
  - A framework for the application and approval process
- Project types to consider:
  - Increases in inpatient psychiatric beds
  - Relocation of inpatient psychiatric beds
  - Introduction of psychiatric services into an existing medical care facility
  - Conversion of beds in an existing medical care facility to psychiatric inpatient beds
- Consideration should be given to project types that are generally non-contested and present minimal health planning impacts

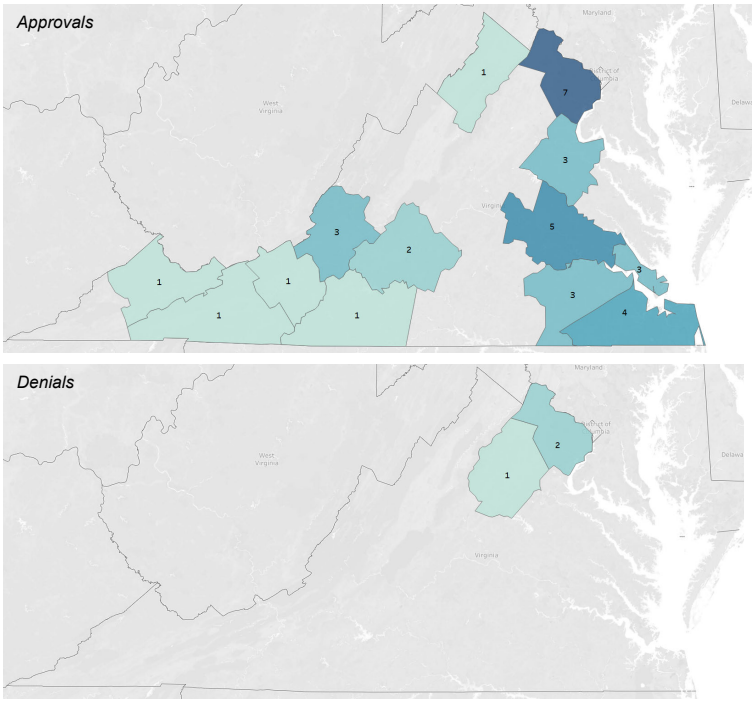
2

Overview – Psychiatric COPN Application Trends

- Since SFY2013 there have been 38 decisions for psychiatric services:
  - 35 were approved
  - 3 were denied
    - One was ultimately approved when resubmitted
  - 673 inpatient psychiatric beds were approved
  - 147 psychiatric beds were denied
    - 33 were subsequently approved under a resubmitted application

3

COPN Approvals & Denials by Planning District – Psychiatric Facilities and Services



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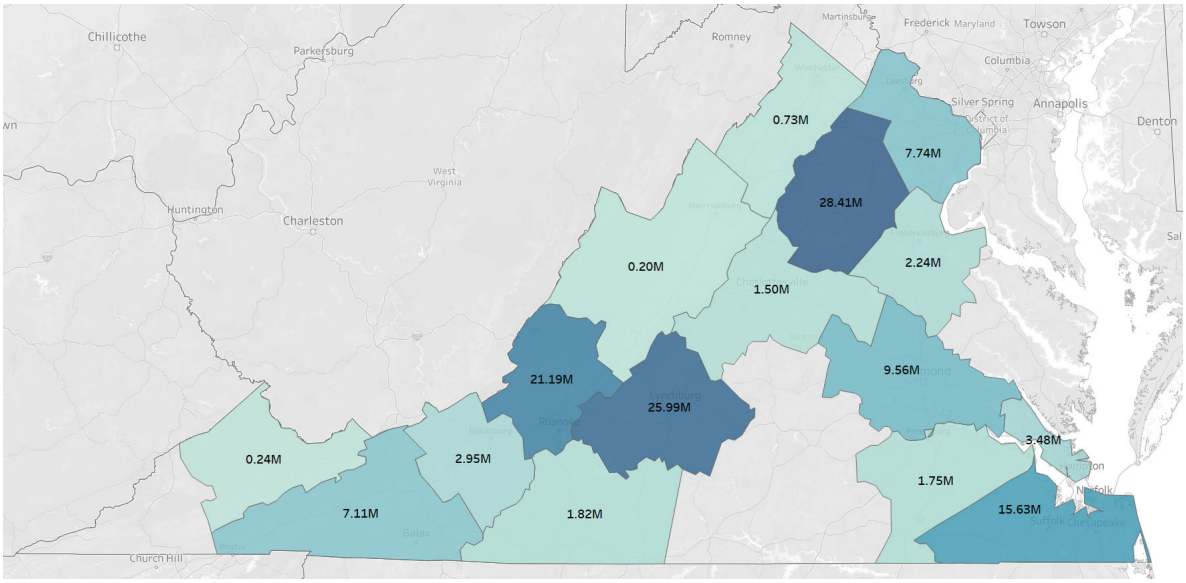
Average Requested Capital Expenditure Cost by Planning District for Psychiatric Projects



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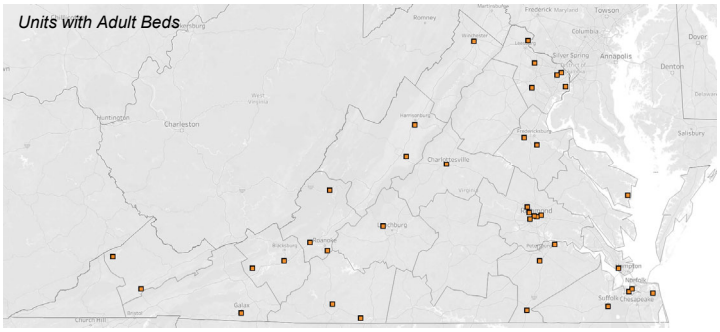
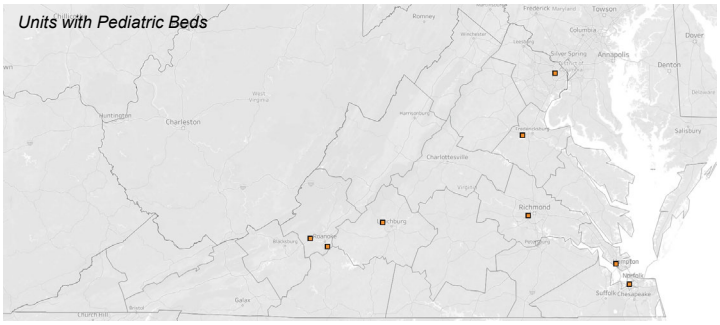
Psychiatric Inpatient Units





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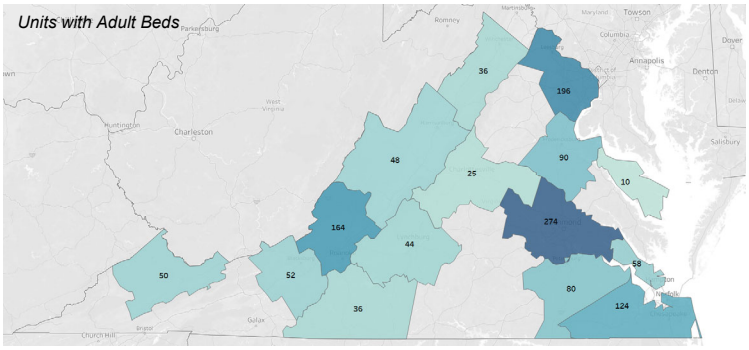
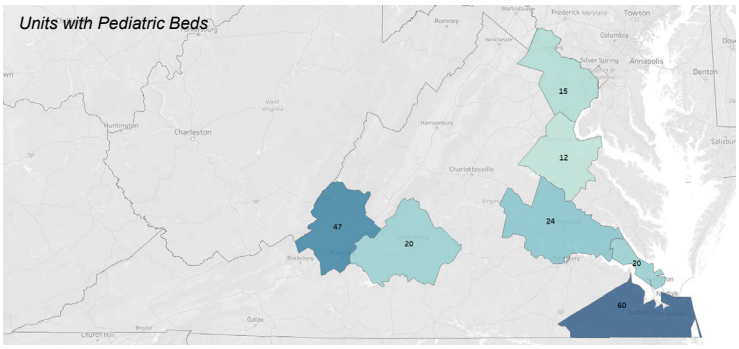
Number of Psychiatric Inpatient Unit Beds





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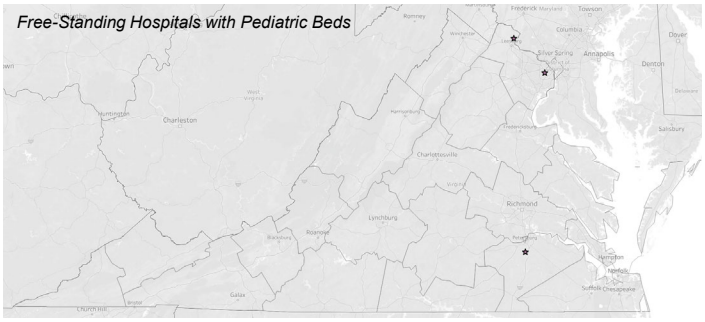
Free-Standing Private Psychiatric Hospitals



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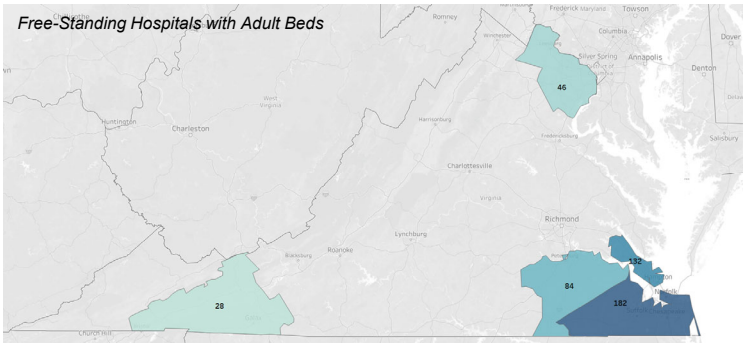
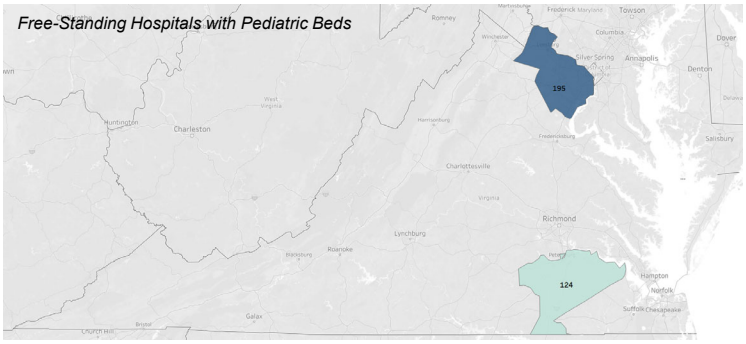
Number of Free-Standing Psychiatric Facility Beds





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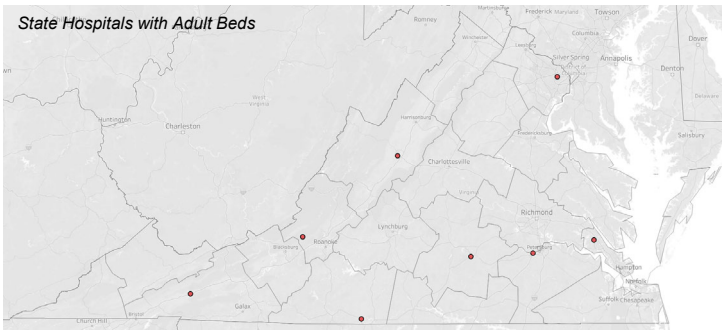
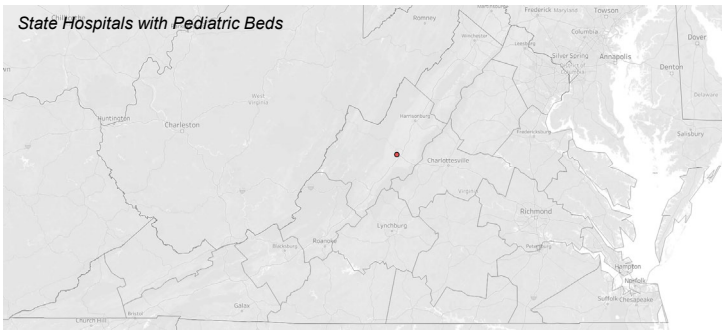
State Psychiatric Hospitals





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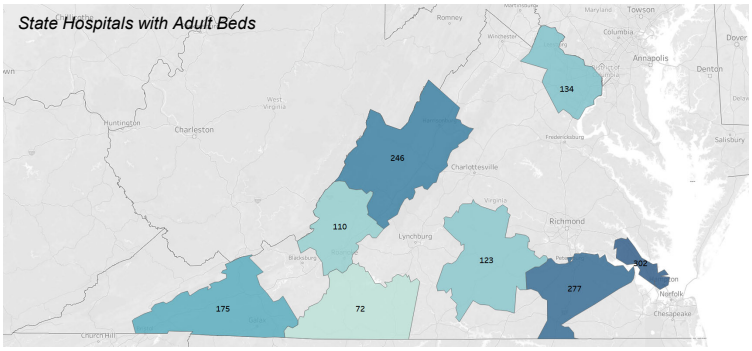
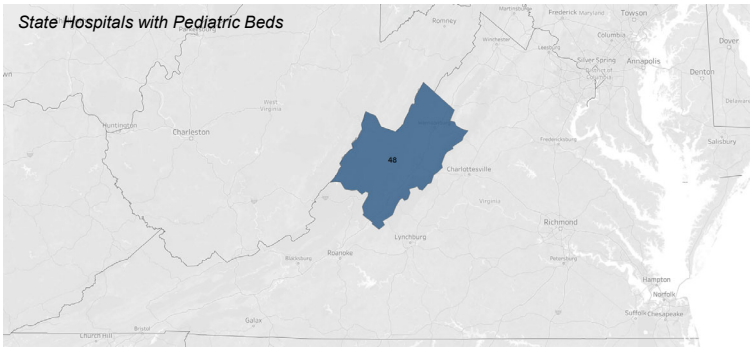
State Psychiatric Hospitals



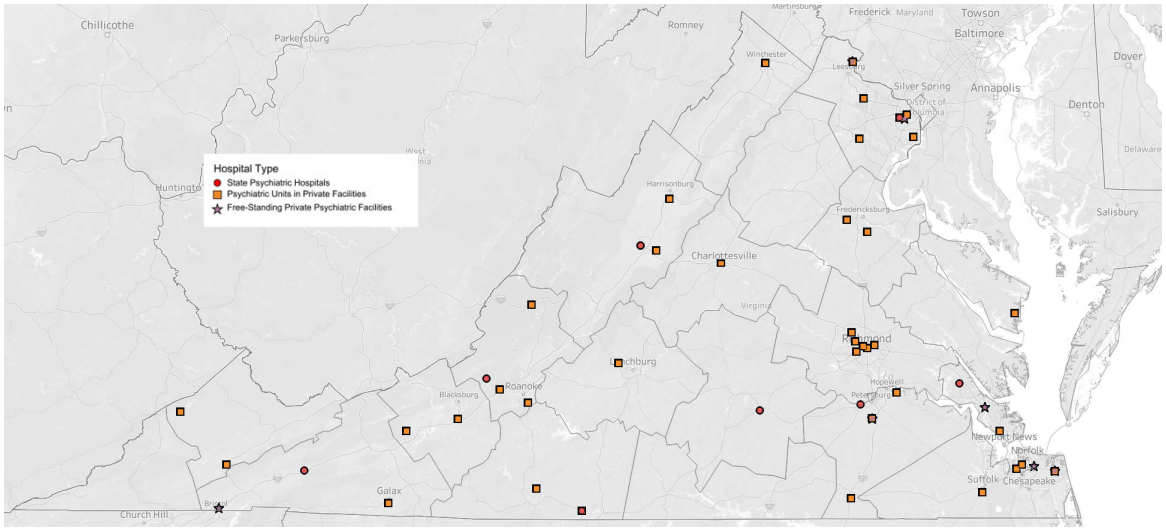


VDH VIRGINIA DEPARTMENT OF HEALTH

Total State Psychiatric Bed Inventory by Hospital

Name	Planning District	Total Number of Beds
Catawba Hospital	5	110
Central State Hospital	19	277
Commonwealth Center for Children and Adolescents*	6	48
Eastern State Hospital	21	302
Northern Virginia Mental Health Institute	8	134
Piedmont Geriatric Hospital	14	123
Southern Virginia Mental Health Institute	12	72
Southwestern Virginia Mental Health Institute	3	175
Western State Hospital	6	246

Psychiatric Units, Free-Standing Facilities, and State Hospitals



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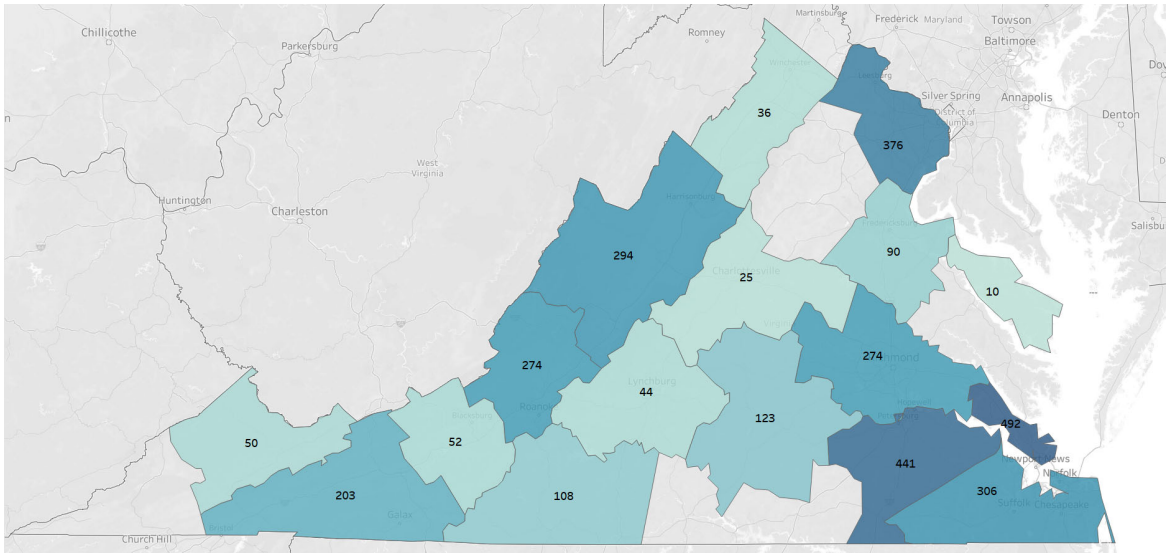
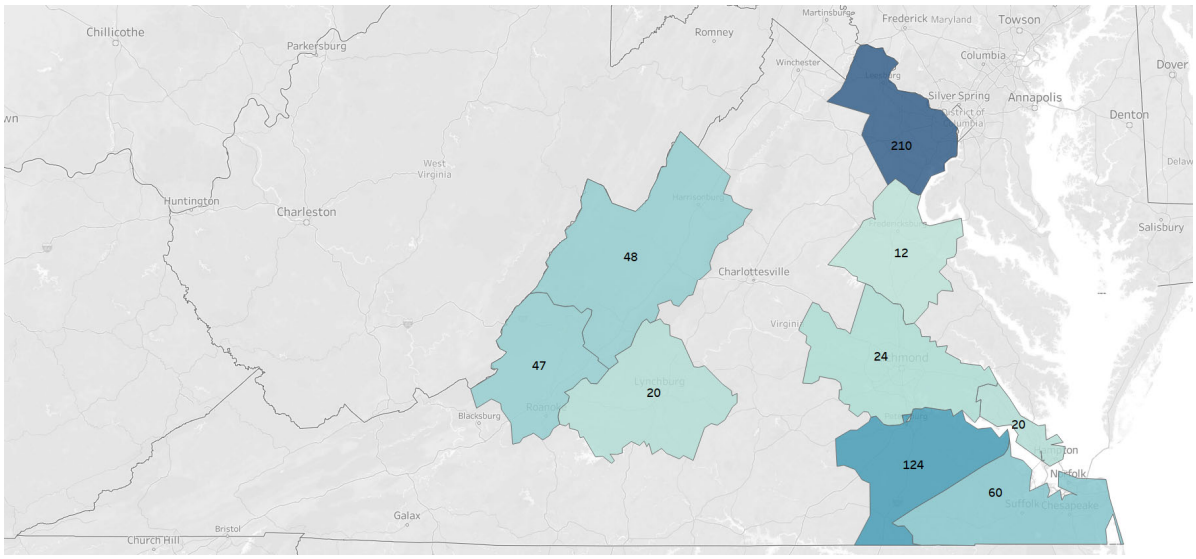
Total Psychiatric Adult Beds by Planning District



14

Total Psychiatric Pediatric Beds by Planning District



15

Past Legislative Efforts – COPN & Psych

- HB1600 (2023) & SB953 (2023) - Expanded the expedited process to include the addition of psychiatric beds and the conversion of existing medical-surgical beds to psychiatric beds
- SB330 (2020) - Proposed the exclusion of mental hospitals, psychiatric hospitals, and intermediate care facilities from COPN
- SB1526 (2019) & SB1141 (2017) - Combined deregulation of COPN for psychiatric hospitals, beds, and services with a replacement permitting process for all 3
- HB1606 (2018) & HB1420 (2017) - Deregulation of COPN for psychiatric hospitals, beds, and services

16

Past Legislative Efforts – Permitting

- Permitting is a more robust registration process contemplated by prior legislation
  - A person would file a permit at least 90 days prior to initiating a project
- Permits would have charity care conditions
- Psychiatric projects have been the focus of permitting, specifically:
  - Establishment of a psychiatric facility
  - An increase in the total number of beds in a psychiatric facility
  - Relocation of beds from one existing psychiatric facility to another
  - Conversion of beds to psychiatric beds
  - Introduction of psychiatric services into an existing medical care facility
  - Any capital expenditure of $15 million or more taken by or on behalf of a psychiatric facility

17

Reduction of Average Time for COPN Review – Study

- Since SFY2013 there have been 38 decisions for psychiatric services:
- Option 6 – Expand eligibility for expedited review
  - Requires a change to § 32.1-102.2(A)(5) to include non-competing requests with capital expenditures below the statutory threshold from existing medical care facilities to increase capacity in an existing service through the addition of:
    - ***Hospital beds (e.g., psychiatric, medical/surgical, etc.)***
    - Cardiac catheterization laboratories
    - Operating rooms
    - CT machines
    - MRI machines
    - PET machines
    - Linear accelerators

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JLARC Report on State Psychiatric Hospitals

- Virginia state psychiatric hospitals face several challenges
  - Recruiting the retaining the staff necessary to safely operate
  - Lack of control over admissions due to the Code requirement for these hospitals to accept temporary detention orders (TDOs)
  - Overreliance on state hospitals due to the underutilization of privately owned psychiatric hospital beds

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Conditioning & TDOs

- JLARC report contained several recommendations relating to TDOs
  - Recommendation 9 – Develop and implement a process to determine a facility's compliance with the COPN condition to accept TDOs, if applicable, and take remedial steps if compliance is not reached
  - Recommendation 10 – Amend ŷ 32.1-102.4 of the Code of Virginia through legislation to require the commissioner to condition the approval of any COPN involving inpatient psychiatric services or facilities on the acceptance of TDOs

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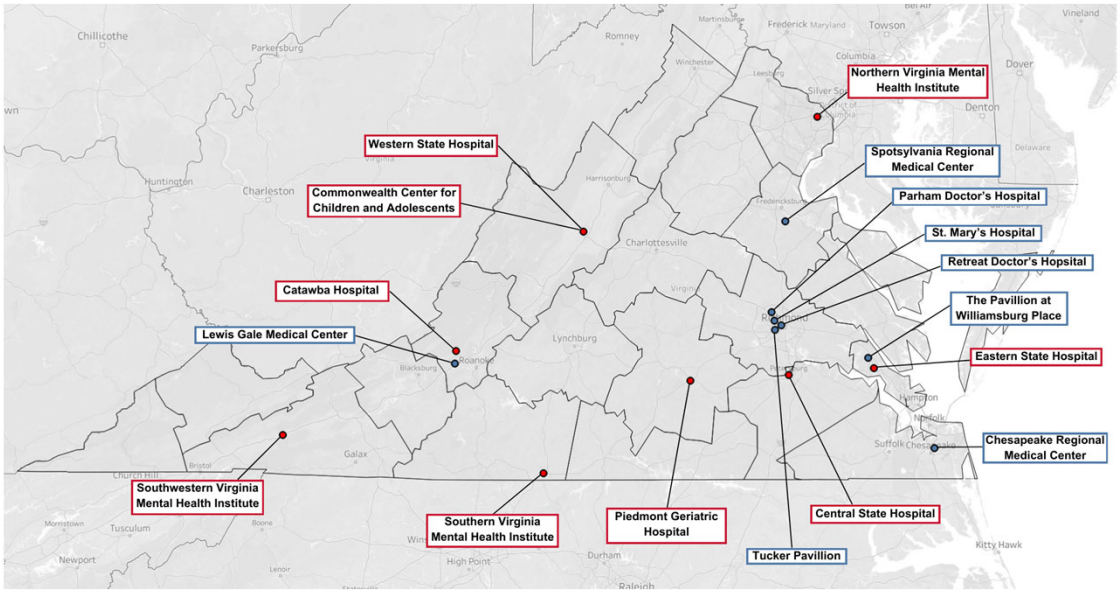
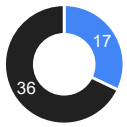
Hospitals with required acceptance of TDOs



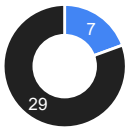
State Comparison

- 36 states have COPN
  - 29 of 36 require a COPN for the construction of new psychiatric facilities
  - Of the 29 states that require a COPN for new construction of psychiatric facilities, 25 of those require a COPN for the introduction of a new psychiatric service that has not been provided in the previous 12 months
  - All 25 of these states also require a COPN for new psychiatric beds

Does the state have COPN?



Does the state require a COPN for new construction?



State Comparison – Bed Conversions

- Of the 25 states that require a COPN for new psychiatric beds:
  - 5 of those states require a COPN to convert psychiatric beds to non-psychiatric beds
  - 7 of those states require a COPN to convert non-psychiatric beds to psychiatric beds
- Unlike Virginia, some of these states may utilize non-COPN guard rails to regulate the conversion of psychiatric beds into non-psychiatric beds, such as through licensure

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State Comparison – Capital Expenditures

- 21 states have capital expenditure requirements for psychiatric projects
  - Most fall between $1,000,000 to $10,000,000
- Maine has project specific capital expenditure requirements
  - Expenditures by or on behalf of existing health care facilities of more than $10,000,000 require a certificate from the department
  - A new health care facility must obtain a certificate if the expected capital expenditure exceeds $3,000,000

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State Comparison - Exceptions

State	Exception
Alabama	Health care facilities with at least 65% med-surg beds may reallocate psychiatric beds without at COPN
Connecticut	Until June 30, 2026 – Increases in bed capacity in a mental health facility are exempt from obtaining a COPN
Georgia	Increases in bed capacity of up to 10 beds or 10% of capacity, whichever is greater, in any consecutive two-year period, in a hospital that has maintained an overall occupancy rate greater than 75% for the previous 12-month period is exempt from obtaining a COPN
Hawaii	Increases in bed capacity of up to 10 beds or 10% of capacity, whichever is greater, in any consecutive 2-year period are exempt from obtaining at COPN
Massachusetts	Single or cumulative increases of 12 or fewer beds are exempt from obtaining a COPN
Nevada	COPN only required for capital expenditures over $2 Million

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Break Out Session

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Questions for Consideration

- What level of COPN review should the following undergo?
  - Psychiatric facilities
  - Psychiatric services
  - Psychiatric beds
  - Capital expenditures related to psychiatric projects
- If a level of review other than standard has been recommended, what should that process look like?
- If a level of review other than standard and expedited has been recommended, should conditioning be available?
  - What conditions?
    - Charity care
    - TDO acceptance
    - Other
  - Should there be required reporting related to these conditions to ensure compliance?
  - If there are TDO conditions, should there be a separate penalty for not complying?

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Break

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Discussion

Supplementary Information

The following information is provided as a reference for members of the Task Force and the public for the March 8, 2024 meeting. It includes:

1. Map of health planning regions in Virginia
2. Map of health planning districts in Virginia
3. Flowchart of the standard review process
4. Flowchart of the expedited review process
5. Excerpts from the December 2023 *Virginia's State Psychiatric Hospitals* report from the Joint Legislative Audit and Review Commission (JLARC)
6. 2021 *Reductions of Average Time for Certificate of Public Need Review* report from the Virginia Department of Health
7. Article 1.1 (§ 32.1-102.1 *et seq.*) of Chapter 4 of Title 32.1 of the Code of Virginia (i.e., the COPN statutes)
8. 12VAC5-220-10 *et seq.*, Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations
9. 12VAC5-230-10 *et seq.*, State Medical Facilities Plan

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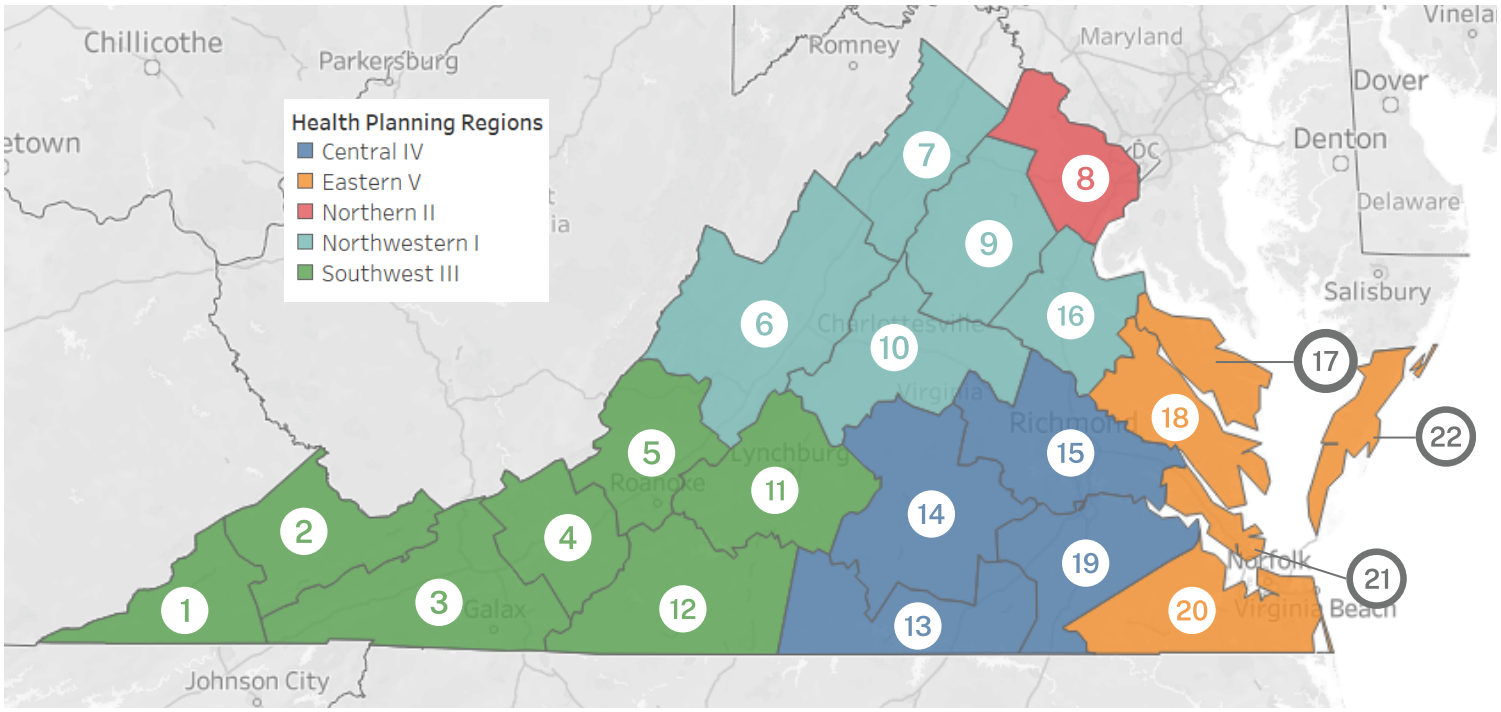
Office of Licensure and Certification
www.vdh.virginia.gov/licensure-and-certification/

State Health Services Plan Task Force



Northwestern I

Planning District 6
Planning District 7
Planning District 9
Planning District 10
Planning District 16

Northern II

Planning District 8

Southwest III

Planning District 1
Planning District 2
Planning District 3
Planning District 4
Planning District 5
Planning District 11
Planning District 12

Central IV

Planning District 13
Planning District 14
Planning District 15
Planning District 19

Eastern V

Planning District 17
Planning District 18
Planning District 20
Planning District 21
Planning District 22

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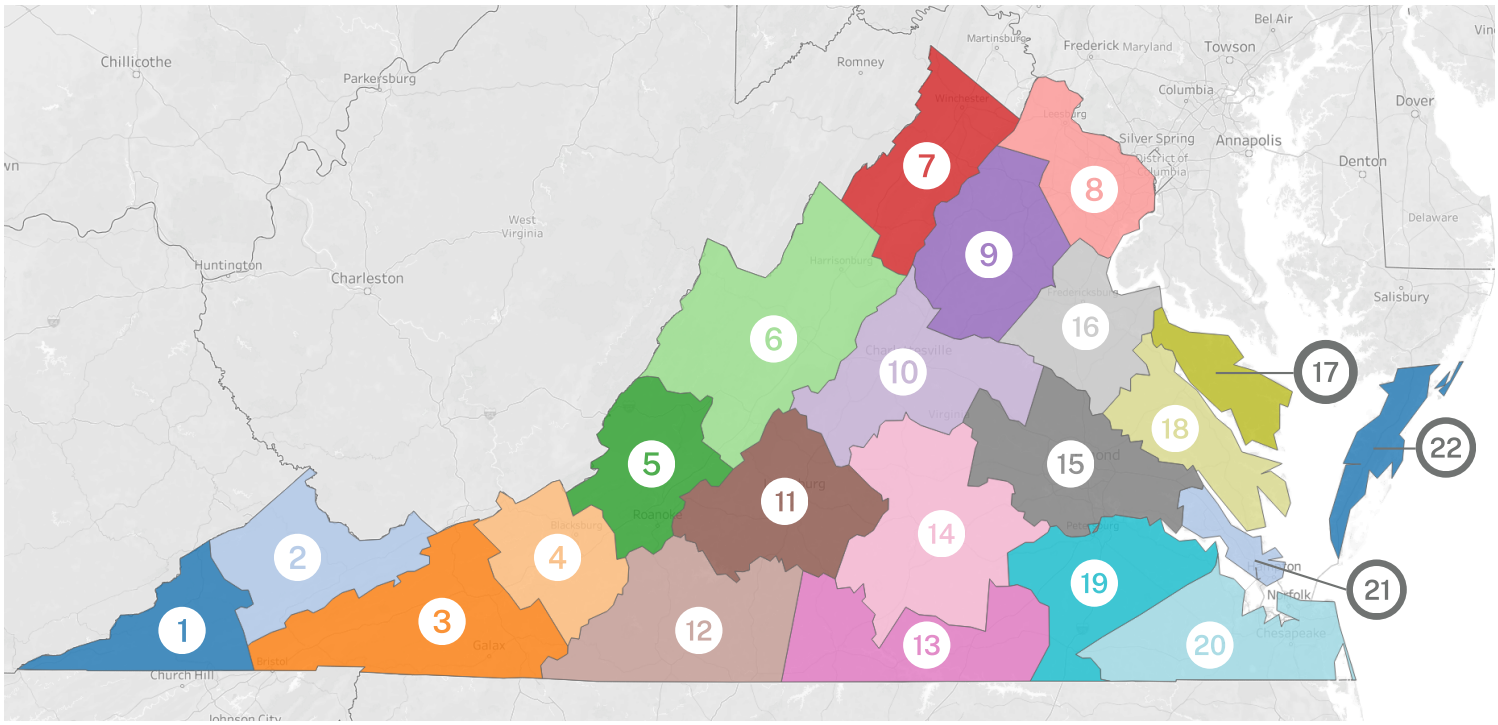
State Health Services Plan Task Force



Planning District 1
City of Norton
Lee County
Scott County
Wise County

Planning District 2
Buchanan County
Dickenson County
Russel County
Tazewell County

Planning District 3
Bland County
Carroll County
City of Bristol
City of Galax
Grayson County
Smyth County
Washington County
Wythe County

Planning District 4
City of Radford
Floyd County
Giles County
Montgomery County
Pulaski County

Planning District 5
Alleghany County
Botetourt County
City of Covington
City of Roanoke
Craig County
Roanoke County
Salem County

Planning District 6
Augusta County
Bath County
City of Buena Vista
City of Harrisonburg
City of Lexington
City of Staunton
City of Waynesboro
Highland County
Rockbridge County
Rockingham County

Planning District 7
City of Winchester
Clarke County
Frederick County
Page County
Warren County

Planning District 8
Arlington County
City of Alexandria
City of Fairfax
City of Falls Church
City of Manassas
City of Manassas Park
Fairfax County
Loudoun County
Prince William County

Planning District 9
Culpepper County
Fauquier County
Madison County
Orange County
Rappahannock County

Planning District 10
Albemarle County
City of Charlottesville
Fluvanna County
Greene County
Louisa County
Nelson County

Planning District 11
Amherst County
Appomattox County
Bedford County
Campbell County
City of Lynchburg

Planning District 12
City of Danville
City of Martinsville
Franklin County
Henry County
Patrick County
Pittsylvania County

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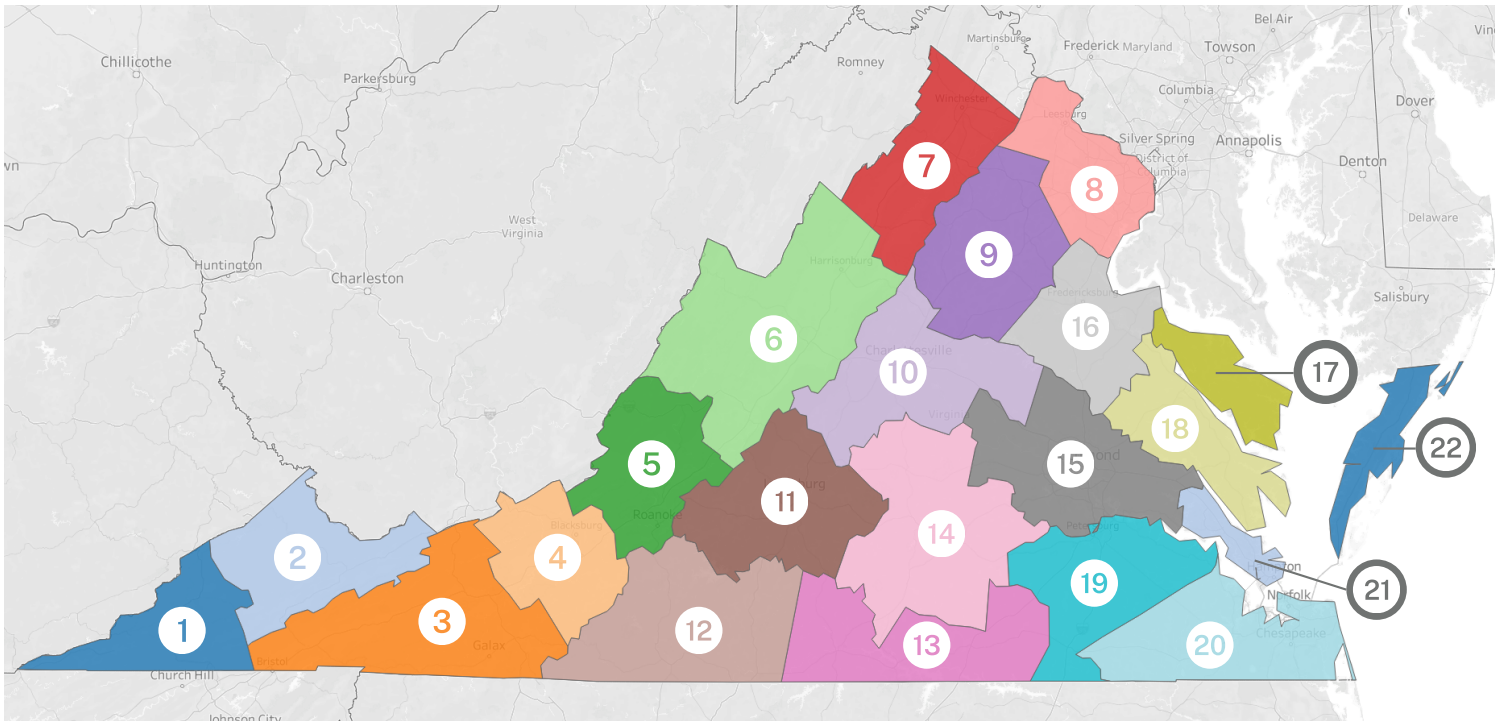
State Health Services Plan Task Force



Planning District 13

Brunswick County
Halifax County
Mecklenburg County

Planning District 14

Amelia County
Buckingham County
Charlotte County
Cumberland County
Lunenburg County
Nottoway County
Prince Edward County

Planning District 15

Charles City County
Chesterfield County
City of Richmond
Goochland County
Hanover County
Henrico County
New Kent County
Powhatan County

Planning District 16

Caroline County
City of Fredericksburg
King George County
Spotsylvania County
Stafford County

Planning District 17

Lancaster County
Northumberland County
Richmond County
Westmoreland County

Planning District 18

Essex County
Gloucester County
King and Queen County
King William County
Mathews County
Middlesex County

Planning District 19

City of Colonial Heights
City of Emporia
City of Hopewell
City of Petersburg
Dinwiddie County
Greensville County
Prince George County
Surry County
Sussex County

Planning District 20

City of Chesapeake
City of Franklin
City of Norfolk
City of Portsmouth
City of Suffolk
City of Virginia Beach
Isle of Wight County
Southampton County

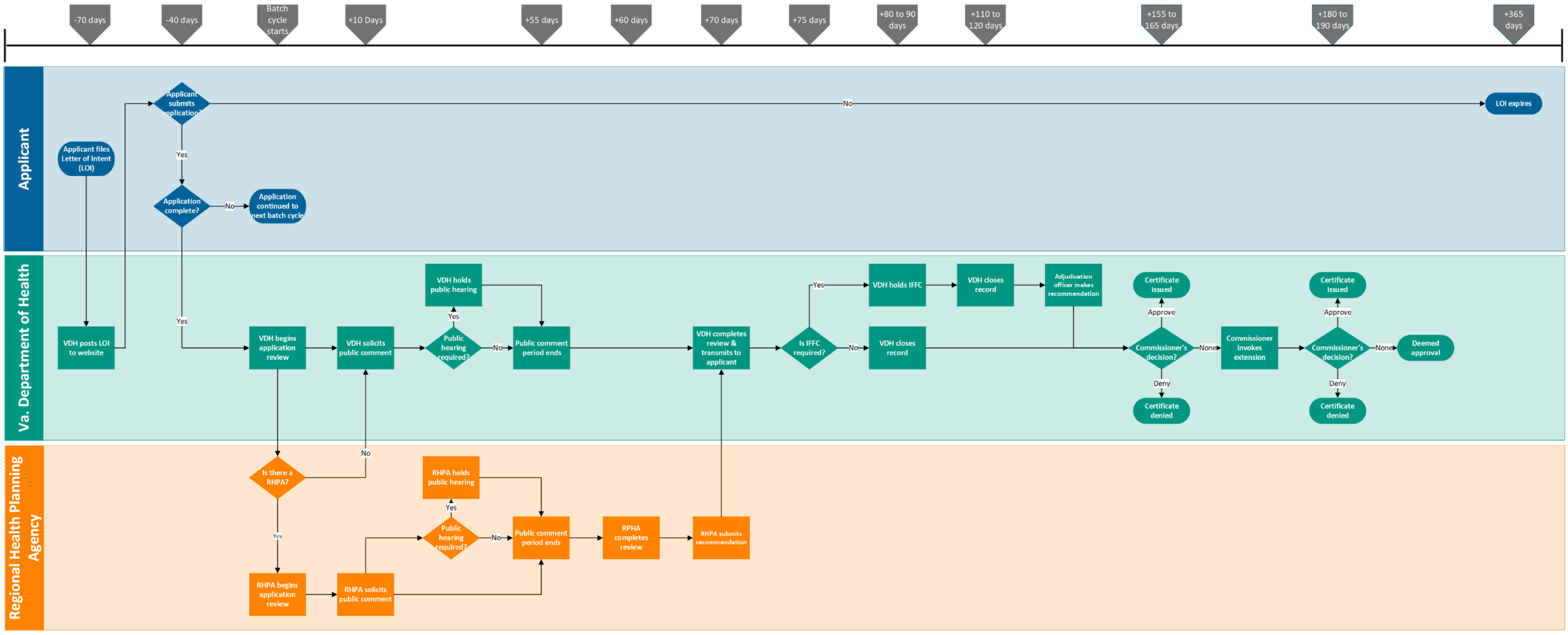
Planning District 21

City of Hampton
City of Newport News
City of Poquoson
City of Williamsburg
James City County
York County

Planning District 22

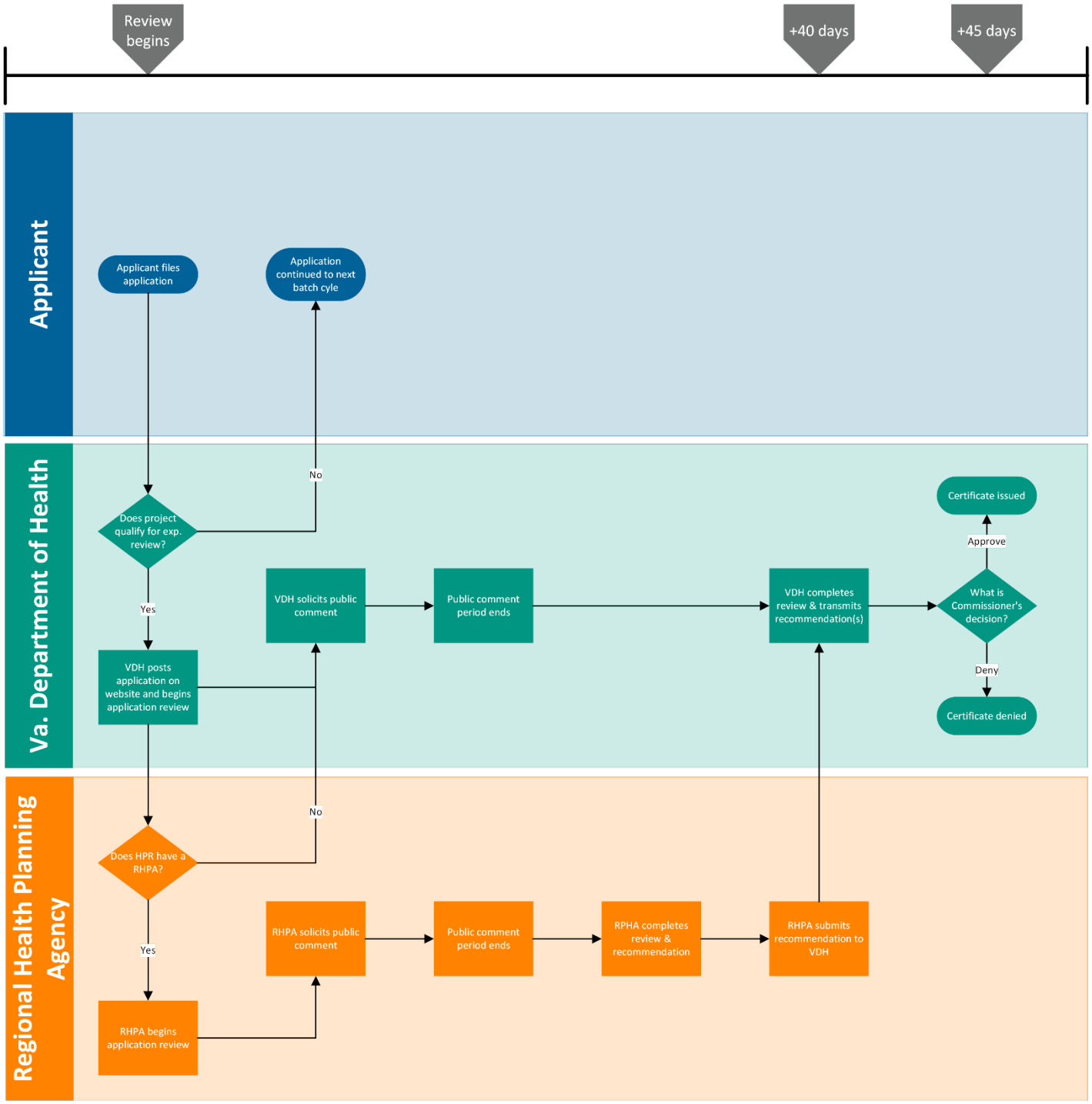
Accomack County
Northampton County

COPN Standard Review Process



1. This visualization of the COPN process has simplified some steps for clarity. Please refer to Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 and 12VAC5-220-10 et seq. for the full details of the COPN standard review.
2. Public hearings are required when there are competing applications or there has been a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public.
3. An informal fact-finding conference (IFFC) is required when determined necessary by VDH or when requested by any person seeking to be made a party to the case for good cause. "Good cause" means 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 VDH's or the RPHA's report on the application.

COPN Expedited Review Process



1. This visualization of the COPN process has simplified some steps for clarity. Please refer to Article 1.1 (§ 32.1-102.1 *et seq.*) of Chapter 4 of Title 32.1 and 12VAC5-220-10 *et seq.* for the full details of the COPN expedited review.

Commonwealth of Virginia
December 11, 2023

Report to the Governor and the General Assembly of Virginia

Virginia's State Psychiatric Hospitals

2023

JLARC
JOINT LEGISLATIVE AUDIT
AND REVIEW COMMISSION

JLARC Report 584

jlarc.virginia.gov

Contents

Summary: Virginia's State Psychiatric Hospitals

WHAT WE FOUND

Virginia's state-run psychiatric hospitals face numerous challenges to effectively treating patients with especially acute psychiatric needs, and one of the greatest challenges is recruiting and retaining staff willing to work in an unpredictable environment that poses personal safety risks daily. The state psychiatric hospital work environment is difficult for nursing and clinical staff, but also the many support staff who are integral to hospital operations. Despite the difficulties inherent in working in such an environment, it is clear that state psychiatric hospital employees are highly committed to providing effective care to patients and providing needed support to their colleagues.

WHY WE DID THIS STUDY

In 2022, the Joint Legislative Audit and Review Commission directed staff to review the inpatient psychiatric hospitals operated by the state.

ABOUT VIRGINIA'S STATE PSYCHIATRIC HOSPITALS

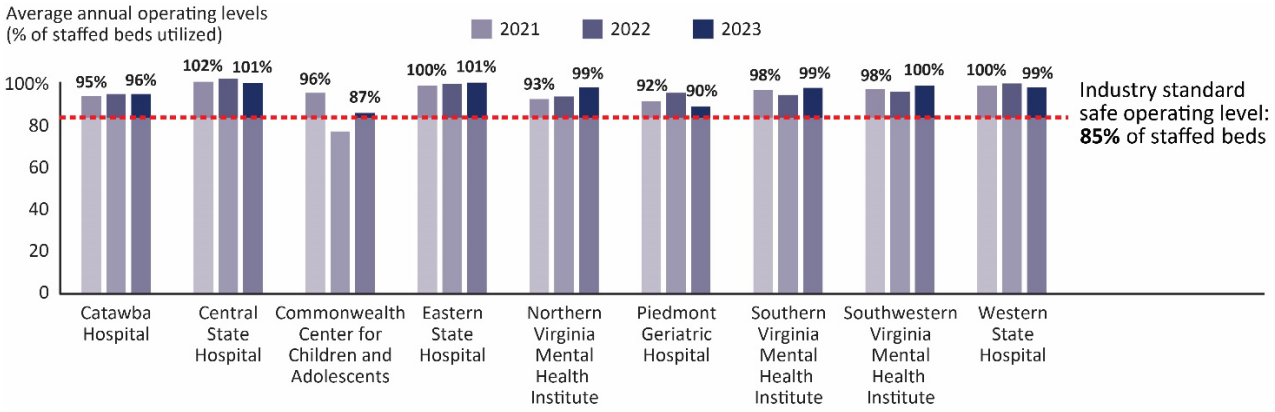
The state operates nine psychiatric hospitals across Virginia, which provide psychiatric treatment services to individuals who are a threat to themselves or others because of mental illness. State hospitals also serve individuals in the criminal justice system, including jail inmates who require inpatient psychiatric treatment and defendants who need inpatient treatment to be able to understand the criminal charges against them. In FY23, about 5,000 individuals were admitted to state psychiatric hospitals, and the largest proportion were under a civil temporary detention order.

State psychiatric hospitals' lack of control over their admissions jeopardizes patient safety

Around half of Virginia's state psychiatric hospital patients are individuals from the community who have been determined to be a threat to themselves or others as a result of a mental illness (i.e, civil patients) and have been admitted involuntarily. Since 2014, state law has required state hospitals to admit individuals who magistrates have placed under a temporary detention order (TDO) if no other placement can be found for them. The legislation was intended to ensure that individuals in need of acute psychiatric services receive treatment, and it removed state hospitals' ability to deny admissions. Since then, state hospitals have experienced significant ongoing capacity constraints and have regularly admitted more patients than they can safely accommodate.

During FY23, seven of the nine state hospitals filled 95 percent or more of their staffed beds, and three regularly filled 100 percent of their beds. According to industry standards, inpatient psychiatric hospitals should not exceed 85 percent of staffed bed capacity to maintain a safe environment. Operating at higher occupancy levels limits hospitals' ability to respond to changing patient needs, such as moving patients to a different room or unit if needed to protect their safety, or protect the safety of other patients and staff, because there is no available extra space. Additionally, being responsible for so many patients limits staff's ability to intervene quickly and effectively in confrontations between patients or between patients and other staff.

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.
NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year.

State hospitals also have seen an increase in inappropriate admissions. If an individual has been determined to meet the criteria for a TDO, but does not actually have a condition that requires psychiatric treatment, statute still requires state hospitals to admit them, which is counterproductive for these individuals' treatment and unsafe for them. These inappropriate admissions include individuals with neurocognitive disorders (i.e., dementia) and neurodevelopmental disorders (i.e., autism spectrum disorder), who accounted for 10 percent of state psychiatric hospital discharges in FY23. While they are a small percentage of state hospital patients, they stay for relatively long periods even though state hospital staff generally do not have the expertise to appropriately care for them. In addition, state psychiatric hospital staff frequently reported concerns regarding the safety and well-being of patients with neurocognitive and neurodevelopmental diagnoses.

Some state hospitals also have seen an increase in individuals who are dropped off by law enforcement before they are admitted, which is unsafe, especially for patients with urgent medical needs. Between FY22 and FY23, law enforcement dropped off 1,432 individuals at state hospitals before they were admitted. Some of these individuals were experiencing urgent medical needs, which state psychiatric hospitals are not equipped to treat. In January 2023, Virginia's attorney general issued an official opinion concluding that law enforcement "dropoffs" at psychiatric hospitals are not permissible under state law. However, more than 450 individuals have been dropped off at state psychiatric hospitals since the issuance of that opinion.

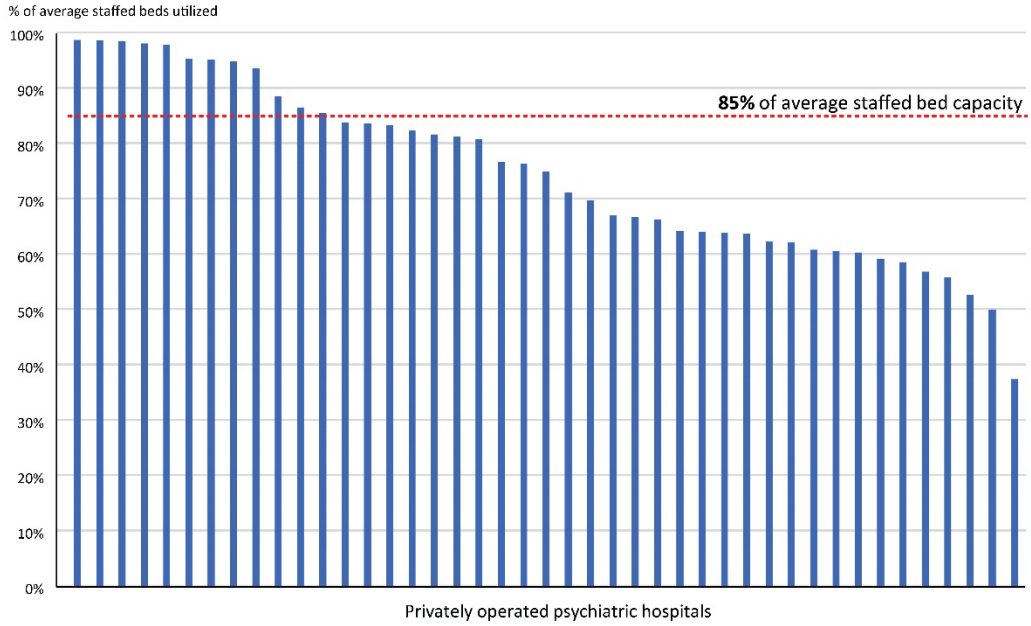
Many private psychiatric hospitals could admit more patients without exceeding safe operating levels

Underutilization of privately operated psychiatric hospital beds places an unnecessary overreliance on state hospitals and can delay or prevent individuals' receipt of needed

treatment. Neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. However, greater utilization of privately operated hospitals would serve a clear public interest and meet a present and growing need to more quickly respond to Virginians who require inpatient psychiatric treatment, reduce the need for law enforcement to wait with patients who need involuntary treatment, and allow state hospitals to operate at safer levels. In FY23, 8,538 individuals under a civil TDO were on a waitlist for admission to a state psychiatric hospital, averaging around 700 individuals per month. Some of these individuals were never admitted to an inpatient facility for further evaluation or treatment, some were dropped off at a state hospital before being accepted by the facility, and some were arrested.

Private psychiatric hospital representatives have previously reported on underutilization of their inpatient psychiatric beds, and the majority of privately operated hospitals operate below the 85 percent staffed capacity level deemed safe for inpatient psychiatric facilities. If private psychiatric hospitals had used a portion of their unused staffed beds in FY22, enough patients would have been diverted from state hospitals to allow both state and private psychiatric hospitals to operate at a safe level.

About two-thirds of private psychiatric hospitals operated below 85 percent of staffed capacity (end of FY22)



SOURCE: JLARC analysis of Virginia Health Information (VHI) data regarding the staffed capacity and patient utilization of private psychiatric hospitals (2022).
NOTE: Four private psychiatric hospitals operated above their average staffed bed capacity. VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Increase in forensic patients has significantly reduced beds available for civil admissions and exacerbated patient and staff safety risks

One reason for the current civil TDO waitlists is the growing number of forensic patients at state hospitals, who are criminal defendants a court has ordered to receive inpatient psychiatric evaluations and/or treatment. Increasing forensic patient admissions have affected all eight state hospitals for adults. Forensic admissions accounted for 47 percent of all admissions to state psychiatric hospitals in FY23. In addition, forensic patients remain hospitalized for about three times longer than civil patients, on average, so increased forensic admissions have substantially reduced state hospital bed capacity for civil admissions, and this trend is expected to continue. Moreover, because the costs of serving forensic patients cannot generally be billed to Medicaid, Medicare, or commercial insurance, growing forensic admissions have increased the state's costs to operate state psychiatric hospitals.

The largest percentage of forensic patients are pre-trial defendants who judges find to be incompetent to stand trial and who must receive services to restore their competency. While many defendants receive outpatient competency restoration services, the majority receive these services on an inpatient basis at the state's psychiatric hospitals. State hospitals have delayed admitting some defendants for competency restoration because of capacity limitations, creating risks that the state will be sued for violating defendants' due process rights, which has happened in at least 16 states. In Virginia, from March through July 2023, 508 defendants were delayed admission to state hospitals for competency restoration. The other categories of forensic patients at state hospitals include individuals in jails or correctional centers who are determined to need inpatient psychiatric treatment under a TDO and individuals found not guilty by reason of insanity.

If state hospitals remain the only inpatient setting for treating forensic patients and no other action is taken to prioritize who is admitted for competency restoration, the capacity pressures they place on state hospitals are likely to worsen. This increasing forensic patient population exacerbates existing staff and patient safety risks because some forensic patients can be especially aggressive, according to state hospital staff. This is particularly concerning in state hospitals that mix civil and forensic patients in the same treatment unit or in the same room.

State hospitals are difficult to staff because of the unsafe working environment and uncompetitive pay for some positions

Statewide turnover across all state hospitals was 30 percent in FY23—over twice as high as the overall state government turnover rate. High turnover rates among state psychiatric hospital staff are a longstanding problem, but turnover has worsened over the past decade. As turnover has increased, positions have become more difficult to fill, leading to higher vacancy rates. The total state hospital staff vacancy rate doubled between June 2013 and June 2022 from 11 percent to 23 percent.

State hospital staff conveyed on a JLARC survey and through interviews that their facilities do not have enough staff to provide adequate care for patients. The majority of nursing and clinical staff responding to a JLARC survey observed their hospitals were insufficiently staffed. Twenty-eight percent of nursing and clinical staff reported that they usually lack enough time to give patients the attention they need, and this was especially common among social workers, case managers, and psychologists.

Virginia does not have specific staffing standards for either its state or privately operated psychiatric hospitals, and there is no industry consensus or federal requirement regarding the ratio of direct care staff to psychiatric hospital patients. A 2022 workgroup composed of chief nurse executives from Virginia state psychiatric hospitals determined a minimum staffing standard for nursing staff, but only one hospital meets that standard, and DBHDS has set a staffing goal below the workgroup's recommendation because of funding constraints.

Most state psychiatric hospitals have increased their use of temporary contract staff to fill vacant positions, raising state hospital operating costs. On a per-staff basis, contractors are much more expensive—between two and three times the cost—than nurses and clinicians employed directly by the facility. In FY23, state hospitals spent at least 9 percent of their operating budget on contract staff ($47 million), 13 times the amount spent in FY13. The amount of total state hospital employee compensation spent on overtime more than tripled over this same time period, from $5.8 million in FY13 to $20 million in FY23. Combined overtime and contracting costs ($67 million) are more than six times higher than the previous decade.

Some state hospital roles are compensated at less-than-competitive rates, but working conditions also contribute to staffing shortages. Positions that were benchmarked to have the least competitive pay compared with the regional median pay were psychologists, social workers, housekeeping staff, and food services staff. While pay increases should be considered, pay is not the only factor making state hospitals difficult to staff. These facilities are some of the most physically dangerous work environments in all of state government; state hospitals have *seven times* the rate of successful workers' compensation claims as employees in other state government agencies.

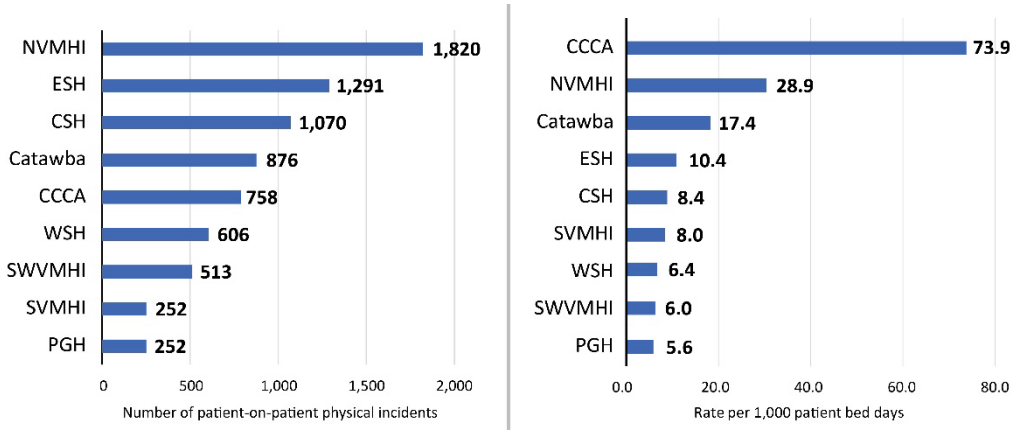
In addition to frustrations with pay and concerns over personal safety, state hospital nursing staff reported dissatisfaction with their hospital's shift schedules. One in four registered nurses who predicted that they would leave their jobs in the next six months cited scheduling as a top reason they were planning to leave. In particular, state hospital leadership and staff expressed frustration with their hospital's inability to offer 12-hour shifts to their employees, which is a standard healthcare industry practice.

Patient safety is a concern, and some Virginia state hospitals use patient seclusion and restraint more often than other states

All hospitals had at least 20 percent of their staff report that they did not believe that their hospital was a safe place for patients, and staff commonly attributed this belief

to high numbers of aggressive patients, increasing numbers of forensic patients, and the admission of patients with neurodevelopmental and neurocognitive disorders. There were about 7,400 known patient-on-patient physical incidents at state hospitals between January 2022 and May 2023 and 1,800 incidents of reported self-injurious behaviors. Across all of these incidents, over 1,400 resulted in patient injuries.

Rates of reported patient-on-patient physical incidents (Jan. 2022 to May 2023)



SOURCE: JLARC analysis of DBHDS Incident Tracker data and Avatar data.
NOTE: The denominator 'patient bed days' is used to measure incidence rates, because it bases incidence rates on the total number of days that patients received care in their hospital, allowing for comparability of incidents across facilities of various sizes. For example, if a facility has 100 beds and each bed is filled by a patient every day of the year, the facility would have 36,500 bed days that year.

State hospital staffing shortages and facility deficiencies, including weaponizable facility features, complicate state psychiatric hospitals' efforts to maintain a safe environment. Most state psychiatric hospitals were not originally designed as inpatient psychiatric hospitals, and various facility deficiencies contribute to safety incidents and hinder staff's ability to keep patients safe. Examples of facility deficiencies include ceramic tiles that can be removed and used as weapons; features like door handles and hinges that present risks to patients intent on harming themselves; hidden alcoves or poor lines of sight; shared rooms at seven hospitals, with at least two hospitals able to accommodate up to four patients in the same room; and lack of modern response mechanisms at four hospitals, which makes it more difficult for staff to efficiently de-escalate aggressive patient behavior or intervene quickly when patient incidents occur.

The use of seclusion and restraint is particularly high at some hospitals, and staff have reported that they and their colleagues are not well trained on how to properly use these methods or respond to patient aggression. State regulation requires all DBHDS-licensed and operated hospitals to use seclusion and restraint only as a last-resort intervention during an immediate crisis, with limits on the length of time adults and children can be subjected to either. Five of the nine state hospitals used higher rates of *restraint* relative to the national average. Six of the nine state hospitals used *seclusion*

at higher rates than national averages. The Commonwealth Center for Children and Adolescents (CCCA) restrains patients at a higher rate than any other state hospital and over 20 times higher than the reported national average. CCCA patients also generally spend a longer amount of time continuously in restraints compared with other hospitals. DBHDS central office made efforts in 2023 to reduce the use of restraint at the facility, including leadership changes and greater attention to de-escalation methods used by staff.

OSIG receives hundreds of complaints but independently investigates only a relatively small portion of them

State hospital staff have unmatched visibility into patients' care and potential safety risks, including possible violations of their personal safety or human rights. However, state hospital staff do not uniformly feel comfortable reporting patient safety concerns to their supervisor or hospital leadership. An independent complaint investigation process is critical to ensuring that patients, visitors, staff, or others have a safe and non-threatening means to raise concerns and can be confident that the investigation of their complaint will have integrity and lead to the proper resolution. The General Assembly has identified this need and assigned Virginia's Office of the State Inspector General (OSIG) to receive and investigate complaints about patient care and safety at state psychiatric hospitals.

OSIG's approach to handling complaints that it receives does not ensure that complaints are independently or thoroughly investigated, counter to the General Assembly's intent. In FY23, OSIG received 633 complaints about DBHDS facilities, but referred most of them back to DBHDS and state hospitals to investigate. OSIG itself reviewed just 117 of those complaints. Independent investigation of patient safety complaints is essential, because referring complaints made to OSIG back to DBHDS and the hospitals could result in complaints not being investigated thoroughly or, worse, being purposely ignored or concealed. It also makes it less likely that appropriate and effective remedies and sanctions will be pursued.

Independent review of a sample of patient records concluded that most sampled patients received satisfactory care, but there were exceptions

The quality of patient care can affect the likelihood of their readmission to an inpatient setting after discharge. Over the past decade, about one in five adults and one in four children discharged from a state psychiatric hospital under a civil status were readmitted within six months. Psychiatrists at VCU Health conducted an independent review of state hospital patient charts for this study. Psychiatrists collectively concluded that most patients in the sample appeared to have received satisfactory care, but there were exceptions. For example, VCU psychiatrists reported concerns about the medication given to 17 of the 45 patients from the sample who received medications during their

hospitalization, including the dosage, appropriateness of the medication for the patient's diagnosis, or adverse side effects. In several instances, reviewers noted concerns about the use of multiple medications simultaneously. Reviewers also observed little documentation by doctors or psychiatric nurse practitioners about the patient's progress or their visits with the patient.

During JLARC staff's visits to the state psychiatric hospitals, staff at several hospitals pointed out deficiencies in the hospitals' physical space that they believed hindered the hospital's ability to provide optimal patient care and treatment. For example, hospital staff highlighted that in some hospitals, there is not enough space to offer small group therapy sessions as often as needed.

Psychiatric hospital for children and youth has persistent operational and performance issues

CCCA is intended to be the facility of last resort for youth experiencing a severe mental illness and who are a threat to themselves or others. However, persistent operational and performance issues at CCCA justify considering whether CCCA should continue to operate. Through various metrics, CCCA stands out as the worst or among the worst performers compared with other state hospitals. For example, it has the highest rate of patient-on-patient and patient-on-staff physical safety incidents, the highest rate of patient self-harm, the highest number and percentage of substantiated human rights complaints, the highest use of physical restraint against patients, the highest staff turnover, nearly the highest staff vacancy rate, and the greatest dependence on expensive contract staff. In a recent unannounced inspection by a national accrediting agency (the Joint Commission), CCCA received 28 citations and was determined to be an immediate threat to the health and safety of patients, according to DBHDS.

CCCA has become more costly to operate, neither patient outcomes nor staffing challenges have improved, and additional investment in the facility is unlikely to result in further improvements. Additionally, most other states do not operate a youth psychiatric hospital.

DBHDS should develop a plan to close CCCA and find or develop alternative placements for the patients who would otherwise be placed there. Following approaches used in other states, including those that do not operate a state hospital for children, the state should contract for services that would better meet the needs of CCCA patients, including private psychiatric hospitals, residential crisis stabilization units, and residential psychiatric treatment facilities, and that are closer to their home communities. State funds used to operate CCCA, about $18 million in FY23, could instead help fund placements for youth who would otherwise be admitted there. If CCCA were closed, at any given time the number of youth needing an alternative placement, such as at a private psychiatric hospital, a crisis stabilization unit, or residential psychiatric treatment facility, would be relatively low (two youths per day, on average).

WHAT WE RECOMMEND

The following recommendations include only those highlighted for the report summary. The complete list of recommendations is available on page xi.

Legislative action

- Exclude behaviors and symptoms that are solely the manifestation of a neurocognitive or neurodevelopmental disorder from the definition of mental illness for the purposes of TDOs and civil commitments so that they are not a basis for placing an individual under a TDO or involuntarily committing them to an inpatient psychiatric hospital, with an effective date of July 1, 2025.
- Grant state psychiatric hospitals the authority to deny admission to an individual under a TDO or civil commitment if the individual's behaviors are solely a manifestation of a neurocognitive or neurodevelopmental disorder and the individual does not meet the criteria for inpatient psychiatric treatment, with an effective date of July 1, 2025.
- Direct the secretary of health and human resources to evaluate the availability of placements for individuals with neurocognitive or neurodevelopmental disorders and identify and develop strategies to support these populations, including through enhanced Medicaid reimbursements or Medicaid waivers, and report results by October 2024.
- Grant state psychiatric hospitals the authority to delay the admission of an individual until it has been determined that they do not have urgent medical needs that the hospital cannot treat.
- Require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need (COPN) for a project involving an inpatient psychiatric facility on the applicant's agreement to admit individuals who are under a civil TDO.
- Provide funding to assist privately operated hospitals with accepting more individuals under a TDO and with discharging patients who face substantial barriers to discharge.
- Grant state psychiatric hospitals the authority to decline admission to an individual under a TDO if doing so will result in the hospital operating in excess of 85 percent of the hospital's staffed capacity, with an effective date of July 1, 2025.
- Provide salary increases for social workers, psychologists, and housekeeping and food services staff.
- Direct the Department of Human Resource Management to allow state hospitals to define nursing staff who work 36 hours per week as full-time staff to facilitate hospitals' ability to use 12-hour shifts.

- Create and fund the number of nursing positions DBHDS has determined are needed to provide quality care at the state's psychiatric hospitals.
- Direct OSIG to develop and submit a plan to fulfill its statutory obligation to fully investigate complaints of serious allegations of abuse, neglect, or inadequate care at any state psychiatric hospital, and develop and submit annually a report on the number of complaints it has received and fully investigated.
- Direct DBHDS to develop a plan to close CCCA and find or develop alternative placements for children and youth.

Executive action

- Virginia Department of Health should develop and implement a process to determine whether all providers granted a COPN based at least partially on their commitment to accept patients under a TDO are fulfilling this commitment and take appropriate remedial steps to bring them into compliance with this commitment, if necessary.
- DBHDS should seek clarification from the Office of the Attorney General regarding whether the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a TDO or civil commitment if the provider has the capacity to do so safely.
- DBHDS should formally solicit proposals from state-licensed psychiatric hospitals or units in Virginia to admit certain categories of forensic patients and work with those hospitals that respond to develop a plan and timeline to contract with them to admit forensic patients.
- DBHDS should study and propose designating certain state psychiatric hospitals or units within them as appropriate to treat only forensic patients.
- DBHDS should contract with a subject matter expert to assess the therapeutic environment for each state psychiatric hospital, prioritizing those with the highest rates of seclusion and restraint.
- DBHDS should develop and implement a process to conduct regular reviews of a sample of state psychiatric hospital patient records to evaluate the quality of care they provide, including procedures for holding hospitals accountable for correcting factors that are determined to cause the delivery of ineffective, unsafe, or generally substandard patient care.

3 Civil Admissions to Private Hospitals

Privately operated, state-licensed psychiatric hospitals ("private psychiatric hospitals") play an integral role in Virginia's overall behavioral health system and treatment of individuals needing inpatient treatment (sidebar). In FY22, 49,350 adults were discharged from a private psychiatric hospital in Virginia—about 10 times as many as the number of people discharged from state hospitals in the same year (~5,000). CSB staff must attempt to place individuals under a temporary detention order (TDO) in private psychiatric hospitals before placing them in a state psychiatric hospital, and the best available data indicates that the majority of patients under a civil TDO are served by a private hospital (sidebar, next page).

For simplicity, this report will refer to all non-state operated psychiatric hospitals as **"privately operated hospitals."** These are freestanding psychiatric hospitals and psychiatric units in general hospitals that are licensed by DBHDS to provide inpatient psychiatric care. These include teaching hospitals that receive public funding for their operations (e.g., University of Virginia Medical Center), but that are not state-operated facilities.

According to data maintained by Virginia Health Information (VHI) and the Department of Behavioral Health and Developmental Services (DBHDS), Virginia has approximately 1,660 adult and 550 youth inpatient beds across 47 private psychiatric hospitals. These beds account for just over half of Virginia's total adult inpatient bed capacity and almost all of its youth bed capacity.

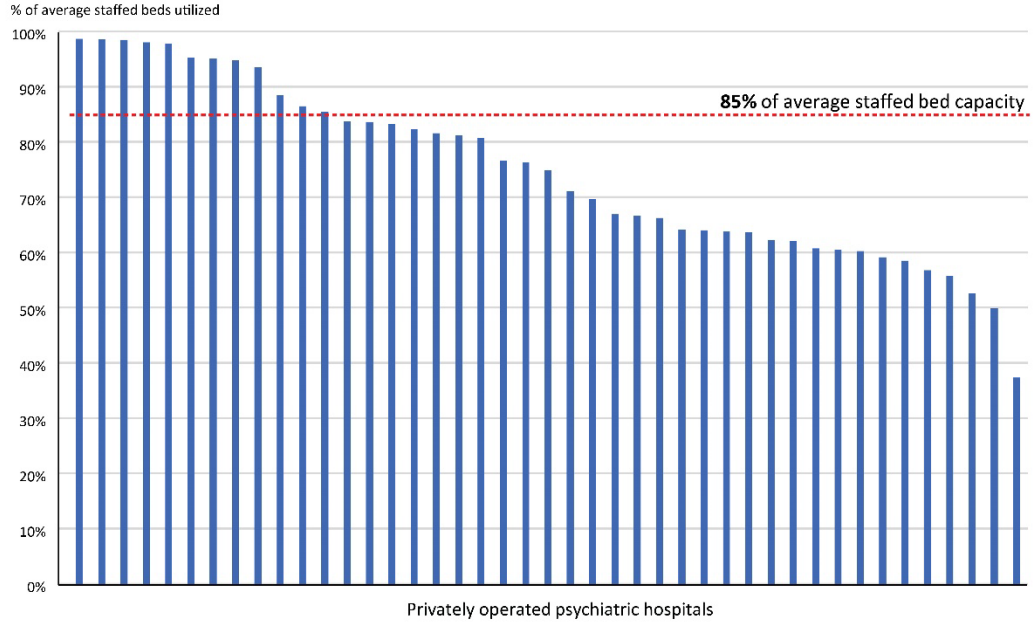
Designating state hospitals as the safety net providers through the Bed of Last Resort law appears to have unintentionally allowed service providers to be more selective in who they admit and avoid admitting, treating, and managing the needs of some Virginians in need of inpatient treatment. Selectivity on the part of many providers has resulted in state psychiatric hospitals being required to admit individuals who could have been served by privately operated hospitals. This is evidenced by excess staffed bed capacity in some privately operated psychiatric hospitals.

Many private psychiatric hospitals could admit more patients without exceeding safe operating levels

While state hospitals have been operating at or near their staffed capacity, the majority of adult private psychiatric hospitals operate below their staffed capacity (Figure 3-1). Adult state psychiatric hospitals have consistently operated at a median of 99 percent of their staffed capacity on a given day between July 2021 and October 2023. Several of these hospitals operated between 100 and 102 percent of their total staffed capacity during this period. According to the most recent available VHI data, 31 of the 43 private psychiatric hospitals for adults used less than 85 percent of their average staffed bed capacity in 2022, which is the industry standard for a safe operating level (sidebar). Many of the hospitals operated far below that level. In the 31 hospitals that operated below 85 percent of staffed capacity, a substantial number of additional inpatient bed days—67,884—could have been used before the hospitals reached 85 percent of staffed capacity.

Information on **private psychiatric hospital beds for children and adolescents** is also reported to VHI but includes residential psychiatric placements. Therefore, a similar analysis to the one presented in this chapter for youth beds is not possible.

FIGURE 3-1
About two-thirds of adult private psychiatric hospitals operated below 85 percent of staffed capacity (FY22)



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals (FY22).
NOTE: VHI utilization data for 2022 includes private psychiatric hospitals' average staffed bed capacity in the facility's 2022 fiscal year. The fiscal year for each privately operated psychiatric hospital may vary.

Private psychiatric hospital beds' underutilization has previously been reported by representatives of these facilities. In 2019, the Virginia Hospital and Healthcare Association (VHHA) surveyed its members and reported that 46 percent of private psychiatric hospitals operated below 85 percent of their staffed capacity.

The number of *unused staffed beds* at adult private psychiatric hospitals increased 38 percent between FY14 and FY22. Some of this increase could at least partially be explained by reduced admissions during the COVID-19 pandemic. However, the largest increase in the number of unused beds occurred around the implementation of the Bed of Last Resort law in 2014 (Figure 3-2).

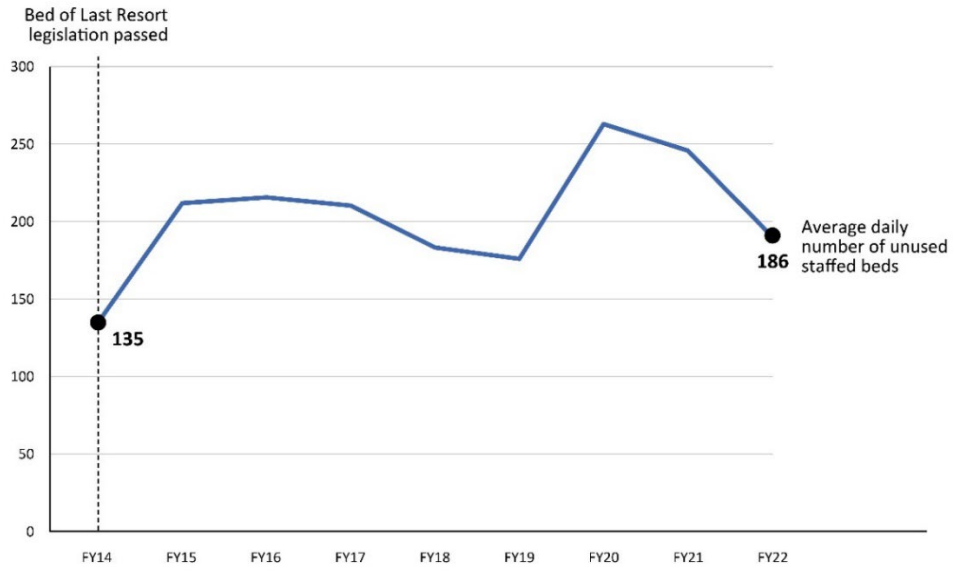
If adult private psychiatric hospitals had used around half of these unused beds in FY22, enough patients would have been diverted from adult state hospitals to allow them to operate at a safe capacity level. If an additional 32,266 bed days in private hospitals had been used to treat adult patients who were ultimately admitted to state hospitals in FY22, state hospitals could have operated at 85 percent of their capacity. At the same time, adult private hospitals would have continued to operate below 85 percent of their average staffed capacity (sidebar). (This analysis assumes that these additional bed days were distributed across all of the adult private psychiatric hospitals that were operating under 85 percent of their staffed bed capacity, Figure 3-3.)

Previous reports to the General Assembly on TDO admissions to private psychiatric hospitals overstated the admissions because the admission figures assumed that any TDO patient not admitted to a state hospital was admitted to a private hospital, but some of those not admitted to a state hospital were never admitted to any inpatient setting.

In the third quarter of FY22, **VHI began tracking the TDO status of individuals** discharged from private psychiatric hospitals. This data could provide more accurate information on the number of TDO patients admitted to private hospitals than is currently being reported.

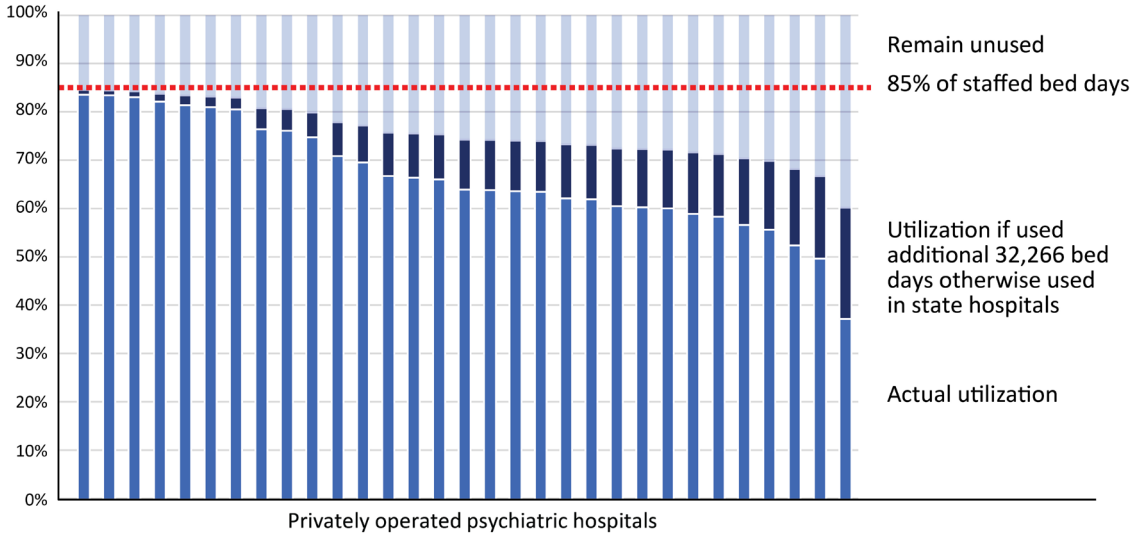
Fewer adult private hospital beds than JLARC's estimates may be needed for state hospitals to operate at safer levels. Reducing forensic admissions to state hospitals and preventing inappropriate TDOs would both increase state hospitals' capacity to accept civil patients and reduce the number of individuals needing temporary detention. (More discussion in Chapters 2 and 4.)

FIGURE 3-2
The statewide average number of unused staffed beds in adult private psychiatric hospitals has increased over time



SOURCE: JLARC analysis of VHI data regarding the staffed capacity and patient utilization of private psychiatric hospitals.
NOTE: Only unused beds that were within 85 percent of the facilities' average staffed bed capacity were counted in this estimate. Additional unused beds exist. See Appendix B for more details.

FIGURE 3-3
Distributing additional bed days across adult private psychiatric hospitals operating below 85 percent capacity would have allowed them to continue operating within safe levels (FY22)



SOURCE: JLARC analysis of VHI data.
NOTE: Additional bed days were distributed across facilities based on the proportion of total unused staffed bed days statewide that they accounted for. Unused staffed bed days included only unused beds that were within 85 percent of a facility's total operating capacity. Thirty-one facilities had unused staffed bed days within 85 percent of their average staffed bed capacity. The fiscal year for each privately operated psychiatric hospital may vary.

This increase in adult private hospital utilization would have had a large positive impact on state hospitals' operations while allowing the private hospitals to continue to operate at safe levels. Many of the challenges discussed throughout this report—safety concerns, staff burnout and turnover, and discharge pressures—stem from high utilization and admission pressures placed on state hospitals.

Private psychiatric hospitals are justifiably concerned about risks that high-need patients create for staff and patient safety

Regardless of funding, general concerns regarding the safety of patients and staff will continue to affect private psychiatric hospitals' willingness or ability to accept additional patients for involuntary admissions. Private psychiatric hospital staff indicated that safety risks to their staff are a key consideration when considering whether to admit additional patients, and some indicated that they felt ill-equipped to protect their staff from especially aggressive or volatile patients.

Private psychiatric hospitals could take several steps to improve their ability to protect their staff from more aggressive and volatile patients. Additional security staff, staff training, and facility improvements were all resources that private hospital staff reported they would need to accept more patients under TDOs or civil commitments. State funding to help cover these costs could incentivize these hospitals to accept more civil TDOs and civil commitments, even if the hospitals could afford to do so without financial incentives. The state already reimburses private hospitals for taking some uninsured patients who would have been admitted to state hospitals from the Local Inpatient Purchase of Services (LIPOS) fund. In FY22, the state allocated around $8.8 million from this fund to cover the costs of serving 993 individuals in private hospitals.

RECOMMENDATION 7

The General Assembly may wish to consider including language and funding in the Appropriation Act directing the Department of Behavioral Health and Developmental Services to establish a program for state-licensed psychiatric hospitals (commonly referred to as "private psychiatric hospitals") to provide funding for those hospitals that agree to increase the percentage of involuntary inpatient admissions they accept and demonstrate the need for funding to safely admit such patients. Funds could be provided to cover one-time and ongoing costs for creating and filling additional security positions, providing staff training on how to safely treat these patients, and making safety improvements to the facilities.

Another approach to incentivizing private hospitals to accept more involuntary admissions would be to provide higher Medicaid reimbursements for involuntary patients. Medicaid is an increasingly important source of revenue for private hospitals; in FY21 (most recent data available), a median of 42 percent of each hospital's patients were enrolled in Medicaid, more than double the proportion in FY18. Policymakers could also explore making eligibility for Medicaid reimbursement contingent on private hospitals' increasing the number of involuntary admissions by a certain amount, but the

permissibility of this approach would need to be reviewed by the Centers for Medicare and Medicaid Services (CMS).

Insufficient funding to support patient discharges from psychiatric hospitals deters private hospitals from admitting certain patients

Various stakeholders indicated that individuals who are likely to face barriers to discharge, including individuals with longer stays and complex conditions, were commonly placed on state hospital civil admission waitlists. One of the most common reasons private psychiatric hospitals reported for denying admission to patients needing involuntary treatment was concern with patients that are challenging to discharge.

Patients who are difficult to discharge cost hospitals more because commercial insurers, Medicaid, and Medicare do not reimburse the costs of their stays after they have been determined to no longer need inpatient treatment. Additionally, hospitals tend to spend more staff time and other resources locating appropriate discharge placements for these patients.

The General Assembly allocates funding to DBHDS for post-discharge services and support for patients in state hospitals who are difficult to discharge through the Discharge Assistance Program (DAP). DAP funding is used to (1) assist with the costs of post-discharge services and placements and (2) develop new post-discharge services and placements when none are available for patients in state psychiatric hospitals who face barriers to discharge. DAP funding is used for supports and services such as in-home services, transportation, medications, and placements in nursing homes, assisted-living facilities, and other less intensive facilities.

In contrast, discharge assistance funding has not been available for patients in private psychiatric hospitals, and these hospitals have been requesting access to these funds to help discharge individuals in a timely manner and reduce the costs of securing post-discharge services and placements for difficult-to-discharge patients. Without access to discharge assistance funding, private hospitals are disincentivized from accepting patients who may be challenging to discharge because they must absorb the cost to arrange the discharge and the cost of the portion of the inpatient stay that extends beyond what is determined to be clinically necessary. In its FY25–26 operating budget request, DBHDS has asked that private psychiatric hospitals have access to available discharge assistance funds.

Allowing discharge assistance funding to support discharges from private psychiatric hospitals could help ensure that they are not disincentivized from admitting patients that they believe will be challenging to discharge.

RECOMMENDATION 8

The General Assembly may wish to consider including language and funding in the Appropriation Act to expand the discharge assistance provided by the Department of Behavioral Health and Developmental Services (DBHDS) to individuals facing substantial barriers to discharge from inpatient psychiatric units and facilities licensed by DBHDS (commonly referred to as "privately operated").

Underutilization of private hospital beds places avoidable burdens on patients, law enforcement, and state hospitals

In FY23, 8,538 individuals under a TDO experienced delays receiving needed psychiatric treatment after they had been deemed an imminent risk to themselves or others because no private psychiatric hospital bed was found for them, and a state hospital bed was not immediately available. Of those individuals, *at least*

- 235 were never admitted to an inpatient facility for further evaluation or treatment—instances the Bed of Last Resort law was intended to prevent;
- 927 were dropped off at a state hospital before being accepted by the facility; and
- 36 were arrested before an inpatient bed was secured because of incidents that occurred while waiting for a bed.

The underutilization of private hospital capacity also prolongs law enforcement officers' involvement in TDO cases and unnecessarily occupies emergency department beds.

The underutilization of private psychiatric hospitals is at least partially due to a reluctance by these facilities to serve certain populations. Current and former leadership and staff of private psychiatric hospitals reported knowing that some *other* privately operated facilities in Virginia do not admit patients they *could* treat. For example, individuals with potential barriers to future discharge were commonly reported to be denied admission to private psychiatric hospitals.

The Bed of Last Resort law likely exacerbates the overreliance on state hospitals to provide inpatient care to individuals needing involuntary psychiatric treatment because it requires state hospitals to accept any individual under a TDO if another placement cannot be secured. The Bed of Last Resort law requires other placements to be sought first, and so its intent is to avoid the use of state psychiatric hospitals unless absolutely necessary. However, neither state law, regulations, nor state licensing standards obligate private hospitals to accept any patient. Multiple national subject matter experts raised concerns that the existing law places undue pressure on Virginia's state psychiatric hospitals because it allows private psychiatric hospitals to be selective in their admissions.

Hospitals are already required to treat individuals in emergencies if they have the capability to do so. Under the federal Emergency Medical Treatment and Labor Act (EMTALA), a hospital is required to treat individuals who need to be stabilized because of an emergency medical condition, either on an inpatient or outpatient basis, when a hospital has the staff and physical capacity to do so. The federal definition of "emergency medical condition" includes individuals experiencing "psychiatric disturbances" that, without immediate attention, "could reasonably be expected to result in placing the health of the individual...in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." This definition includes individuals who are substantially likely to be an imminent risk to themselves because of mental illness—one of the three circumstances by which an individual may meet the criteria for involuntary psychiatric treatment in Virginia. At least in some circumstances, private hospitals that do not admit TDO patients whom they have the ability to treat into their psychiatric units would be in violation of EMTALA.

State could use the certificate of public need process to ensure that privately operated hospitals accept TDO patients

State law requires that healthcare providers receive a certificate of public need (COPN) from the state health commissioner before undertaking a project to establish, expand, or relocate certain types of medical facilities, including inpatient psychiatric facilities or units within general hospitals. Most states (35), including Virginia, operate a COPN process, and the general purposes of such a process are to control costs by avoiding unnecessary expansion or duplication of services in an area and to improve access to underserved areas or populations.

To receive a COPN in Virginia, a healthcare provider must demonstrate through an application process that the proposed project meets a public need, according to criteria specified in state law. State law also requires the state health commissioner to condition the approval of any COPN on the applicant's agreement to meet certain conditions. These conditions include "to provide a specified level of charity care to indigent persons" or to "accept patients requiring specialized care." If the COPN is issued, the provider must meet those conditions annually or be subject to a civil penalty. Furthermore, when a provider applies for a COPN to operate psychiatric inpatient beds, state regulations require the Virginia Department of Health to give preference to proposals "demonstrating a willingness to accept persons under a temporary detention order."

State law does not specify who should be considered "patients requiring specialized care" in the COPN process.

In their COPN application, some private psychiatric hospitals have committed to accepting TDO patients. Between January 2021 and September 2022, the state health commissioner granted approval to nine projects seeking to add inpatient psychiatric beds, and in four of them, the approval was partially based on the applicant's commitment to accepting TDO patients.

To improve access to inpatient care for TDO patients, the state health commissioner should develop and implement a process to ensure that providers who have committed in their COPN application to serve TDO patients are fulfilling this commitment. If

providers are found not to be meeting their commitment to serve TDO patients, the commissioner, using the authority granted in state law, should take appropriate steps to bring the provider into compliance. State law authorizes the commissioner to impose civil penalties if providers refuse, fail, or neglect to honor agreed-upon conditions.

The VHI, which reports to the Virginia Department of Health, now collects information to identify the number and proportion of patients admitted to each hospital who were under a TDO at the time of admission. The Virginia Department of Health should use this information as part of its review process to determine the extent to which hospitals are meeting their commitments.

RECOMMENDATION 9

The Virginia Department of Health should develop and implement a process to (i) determine whether all healthcare providers that were granted a certificate of public need based at least partially on their commitment to accept patients under a temporary detention order (TDO) are fulfilling this commitment, and (ii) take appropriate remedial steps to bring providers who are determined to not be fulfilling their commitment into compliance.

The General Assembly should establish in state law that providers must agree to accept TDO patients as a condition of *future* COPN approvals related to inpatient psychiatric beds. This change would apply to projects seeking to open a new inpatient psychiatric hospital or add inpatient psychiatric beds to an existing facility. State law already has a precedent for requiring a COPN applicant to commit to serving certain categories of patients (i.e., providing charity care or serving individuals who require specialized care), and accepting patients under a TDO follows this precedent.

RECOMMENDATION 10

The General Assembly may wish to consider amending § 32.1-102.4 of the Code of Virginia to require the commissioner of the Virginia Department of Health to condition the approval of any certificate of public need for a project involving an inpatient psychiatric service or facility on the agreement of the applicant to accept patients under a temporary detention order whenever the provider has the capacity and capability to do so.

Because the previous two recommendations would only affect *new inpatient psychiatric beds* or *providers that previously committed to serving TDOs*, the General Assembly could consider and evaluate other options to require existing inpatient facilities to accept patients under a TDO, even if they did not previously commit to doing so as part of their COPN application. For example, the General Assembly could consider requiring that projects seeking to expand inpatient psychiatric services only be considered by the Virginia Department of Health commissioner if either they (1) previously agreed to accept TDO patients in their prior COPN application(s) or (2) agree to accept TDO

patients in at least some of their existing facilities going forward. However, these legislative changes and their impacts would need to be further evaluated and may not be necessary if DBHDS already has the authority to require providers to accept TDO patients, as described below.

DBHDS may already have the authority to require that private psychiatric hospitals serve TDO patients

Another option that the executive branch could consider to help patients under a TDO receive the care they need and alleviate pressures on emergency rooms, law enforcement officers, and state hospitals is for the DBHDS commissioner to use existing authority granted to him under state provider licensure requirements. DBHDS licenses providers of inpatient psychiatric services, including private psychiatric hospitals and psychiatric units within general hospitals, and state regulations authorize the DBHDS commissioner to impose additional requirements on licensed providers:

> The commissioner may add stipulations on a license issued to a provider…to impose additional requirements on the provider *(12VAC35-105-50.B)*

Because DBHDS-issued licenses must be renewed at least once every three years, DBHDS could potentially use this authority to prohibit licensed providers from denying admission to an individual under a TDO when the provider is operating below 85 percent of staffed capacity. Exceptions could be allowed when a provider demonstrates that accepting the individual would jeopardize the individual's safety or the provider's ability to care for their existing patients. DBHDS has the authority to implement sanctions for non-compliance, including issuing fees, prohibiting new admissions, and reducing the licensed capacity of a facility.

Such a requirement would be consistent with the expectations under EMTALA, which specify that hospitals should not deny admission to patients experiencing an emergency condition if they have the capability and capacity to treat them.

Massachusetts has used its licensing authority to take such action. The Massachusetts Department of Mental Health specifies in its licensing regulations that privately operated psychiatric hospitals, which are licensed by the department, cannot deny admission of involuntary patients when they have the capability and capacity to treat them. This provision was promulgated to address the recurring problem of involuntarily detained mental health patients spending protracted amounts of time in emergency rooms waiting to be admitted to an inpatient unit or facility for mental health treatment. The requirement is consistent with EMTALA's requirements, according to Massachusetts department staff. Staff reported that the provision has helped increase the rate at which private hospitals admit involuntary patients, including those with more challenging conditions and behaviors.

Because DBHDS licensure regulations are generally related to patients who are receiving services through licensed providers (rather than those who *could* be receiving services), DBHDS should seek clarification from the Office of the Attorney General

about this authority. If the Office of the Attorney General determines that the DBHDS commissioner has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to accept TDO patients if they can do so safely, then the commissioner should use this authority and develop and implement processes to ensure compliance with it.

RECOMMENDATION 11

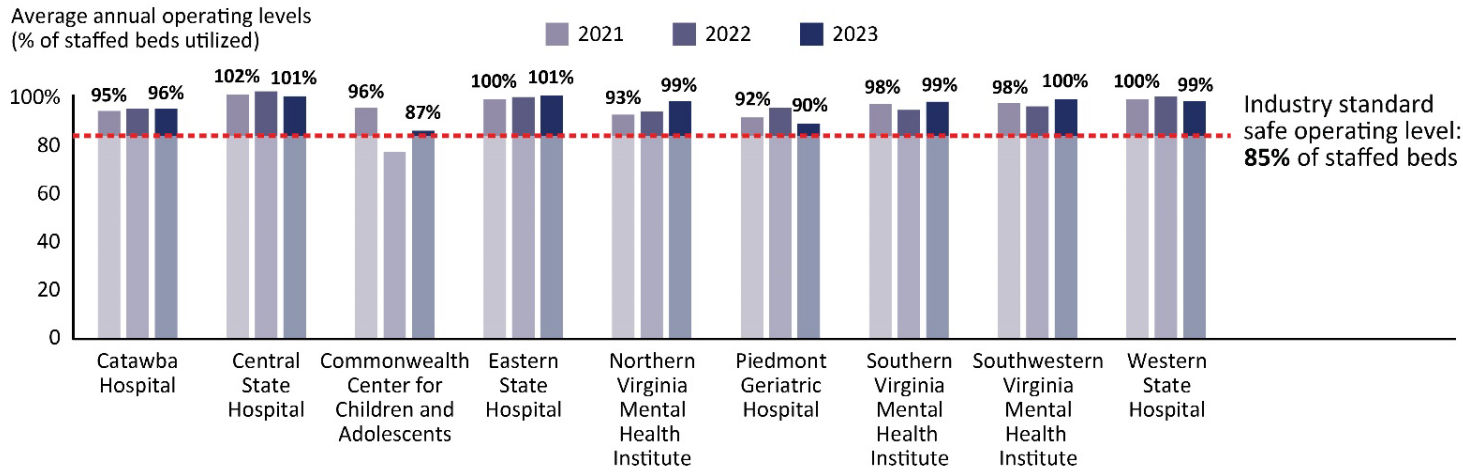
The Department of Behavioral Health and Developmental Services (DBHDS) should seek clarification from the Office of the Attorney General regarding whether the commissioner of DBHDS has the legal authority pursuant to 12VAC35-105-50.B to require providers of inpatient psychiatric services to admit patients under a temporary detention order or civil commitment order if the provider has the capacity to do so safely.

State hospitals should be given the authority to deny admissions based on their staffed capacity

In recent years, all state hospitals have been operating above 85 percent of their staffed bed capacity, and several have regularly exceeded their staffed bed capacity. During 2023, seven state hospitals had an average annual operating level of at least 95 percent of staffed beds, and three regularly filled all their staffed beds (Figure 3-4).

FIGURE 3-4

All state hospitals have been regularly operating above the industry standard for safe operating levels



SOURCE: JLARC analysis of DBHDS data on utilization of staffed beds at each hospital.

NOTE: Figures reflect each facility's average staffed bed operating levels and are based on monthly snapshots reported for each facility throughout each fiscal year. Information on staffed beds was available from July 2021 through October 2023.

Operating at these high levels limits the facilities' ability to respond to changing patient needs, in terms of providing appropriate bed placements, treatment, and staff supervision. As expected, DBHDS and state hospital staff reported that it has had detrimental impacts on staffing, the safety of patients and staff, and the quality of care provided—concerns discussed in more detail throughout this report:

> Unsafe staffing conditions are exacerbated when we are forced to go over census. This is a significant risk for staff and patients and ultimately a risk for the system overall. It seems like just a matter of time until a related sentinel event occurs somewhere in the system. (state hospital staff)

> Having a hospital at 100 percent capacity for several years on end is not sustainable; results in poor care, unsafe working conditions, and staff leaving. (state hospital staff)

> The admissions policy that requires this facility to take in more clients regardless of our facility's ability (or lack thereof) due to staffing and bed availability, is not only dangerous for all involved but sends a clear message to the employees that they are not important or valued. Something has to give! People are frustrated and many are getting hurt or worse. (state hospital staff)

State psychiatric hospitals should have the ability to deny civil admissions, at least temporarily, if they are operating at levels that are generally considered unsafe. However, state hospitals currently have no authority to deny admission for civil patients under state law:

> Under no circumstances shall a state facility fail or refuse to admit an individual who meets the criteria for temporary detention… unless an alternative facility that is able to provide temporary detention and appropriate care agrees to accept the individual for temporary detention

This is much more prescriptive than the regulatory admissions requirements for privately operated psychiatric hospitals, which shall only admit individuals "for which staffing levels and types meet the needs of the individuals receiving services." Providing similar flexibility for state psychiatric hospitals is necessary to improve the safety of these facilities and the ability of staff to properly care for patients.

Two equally important goals should guide efforts to provide needed treatment for Virginians placed under TDOs: ensure that the hospitals offer an environment that is as safe and therapeutic as possible *and* ensure that all Virginians who meet TDO criteria and need inpatient psychiatric treatment are placed, without delay, in an appropriate inpatient setting. To achieve the first goal, state psychiatric hospitals should have the statutory authority to pause new admissions when they are operating at 85 percent of their staffed capacity. However, doing this alone will increase the risk that individuals experiencing a mental health crisis will not receive needed inpatient care (although this already occurs because of civil admission waitlists and the expiration of TDOs before treatment can be provided.) Therefore, DBHDS and the General Assembly should also follow the recommendations provided earlier in this chapter to expand access to other existing inpatient beds in privately operated psychiatric hospitals.

Virginia also needs to build out new community-based resources, like crisis receiving centers that can accept TDO patients, which the General Assembly, DBHDS, and community services boards have already begun to do. However, this cannot be the sole strategy for helping Virginians experiencing a mental health crisis because it will take time and significant financial resources. Further utilizing state-licensed privately operated hospitals with unused capacity can help in the near term to provide more Virginians placed under TDOs with timely care.

Allowing state hospitals to deny involuntary admissions based on their staffed capacity is an essential component of ensuring that state hospitals can provide environments that are safe and therapeutic for patients and safe and more predictable for staff. (See Chapters 5 and 6 for further discussion of patient and staff safety.) However, it is prudent to give the state time to prepare for this change and allow state officials and other stakeholders to take steps to avoid unintended consequences. For example, waitlists for admissions to inpatient facilities, which are already a concern, could grow if other resources for patient treatment are not identified or developed. Therefore, if legislation is enacted to grant state hospitals the authority to deny admission to individuals under a TDO when they reach 85 percent of their staffed capacity, its effective date should be delayed by the General Assembly until 2025.

RECOMMENDATION 12

The General Assembly may wish to consider amending the Code of Virginia to grant state psychiatric hospitals the authority to decline to admit any individual under a temporary detention order if doing so will result in the hospital operating in excess of 85 percent of its total staffed capacity. The legislation's effective date should be delayed until July 1, 2025.

REPORT OF THE VIRGINIA DEPARTMENT OF HEALTH

Reductions of Average Time for Certificate of Public Need Review (Chapter 1271, 2020)

TO THE GOVERNOR AND THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

COMMONWEALTH OF VIRGINIA
RICHMOND
2021

REDUCTIONS OF AVERAGE TIME FOR CERTIFICATE OF PUBLIC NEED REVIEW

REPORT TO THE GENERAL ASSEMBLY

VIRGINIA DEPARTMENT OF HEALTH
OFFICE OF LICENSURE AND CERTIFICATION
DIVISION OF CERTIFICATE OF PUBLIC NEED

PREFACE

The Virginia Department of Health (VDH) is submitting this report in response to the legislative mandate in the second enactment clause of Chapter 1271 of the 2020 Acts of Assembly, which directed VDH to develop recommendations to reduce the duration of the average review cycle for applications for Certificates of Public Need to not more than 120 days from the date of receipt of a Letter of Intent. The legislative mandate requires VDH to report its recommendations "to the Governor and the General Assembly by December 1, 2020."

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EXECUTIVE SUMMARY

The Commonwealth of Virginia maintains control over the supply of certain medical care facilities and health services through its certification of public need (COPN) program. Certain projects (e.g., opening a hospital, adding beds to a nursing home, etc.) require the project owner to demonstrate that there is a public need for that specific project before the project can be commenced. Depending on the project, it may be eligible for an expedited review process. The process of reviewing COPN applications can be a lengthy one. The General Assembly directed the Virginia Department of Health (VDH) to develop recommendations to reduce the duration of the average review cycle for the review of a COPN request to not more than 120 days. VDH is recommending the following changes to the COPN program to achieve an average review cycle of 120 or fewer days from receipt of the Letter of Intent (LOI) to the State Health Commissioner's (Commissioner) decision:

1. Reduce the time between the LOI and application submission from 30 days to 14 days, which is a reduction of 16 days.
2. Reduce the time between the application submission and start of the review cycle from 40 days to 5 days, which is a reduction of 35 days.
3. Reduce the time for staff review of COPN applications from 70 days to 65 days, which is a reduction of 5 days.
4. Reduce the time between an informal fact-finding conference and the close of the record from 30 days to 28 days, which is a reduction of 2 days.
5. Reduce the time between the close of the record and State Health Commissioner's decision from 45 days to 40 days, which is a reduction of 5 days.
6. Expand the types of COPN requests that are eligible for expedited review to include non-competing requests with capital expenditures below the statutory threshold from existing medical care facilities to increase capacity in an existing service through the addition of:
    a. medical/surgical beds;
    b. hospice beds;
    c. psychiatric beds;
    d. rehabilitation beds;
    e. cardiac catheterization laboratories;
    f. operating rooms;
    g. computed tomographic imaging machines;
    h. magnetic resonance imaging machines;
    i. positron emission tomography machines; and
    j. linear accelerators.

Implementation of these recommendations would require certain amendments to the Code of Virginia and to the Virginia Medical Facilities Certificate of Public Need Rules and Regulations as described herein.

INTRODUCTION

The Division of Certificate of Public Need (DCOPN) in the Virginia Department of Health's (VDH) Office of Licensure and Certification (OLC) is the unit responsible for the administration of the Certificate of Public Need (COPN) program.

REPORT MANDATE

The second enactment clause of Chapter 1271 (2020 Acts of Assembly) requires that recommendations to reduce the duration of the average review cycle for the review of a COPN request be reduced to not more than 120 days be submitted to the Governor and General Assembly by 1 December 2020. The recommendations contained in this report are to achieve an average of no more than 120 days from receipt of the Letter of Intent (LOI) to the State Health Commissioner's (Commissioner) decision.

CURRENT COPN REVIEW PROCESS

The applicability and process for the COPN program is established in Article 1.1 (§ 32.1-102.2 *et seq.*) of Chapter 4 of Title 32.1 of the Code of Virginia. More specifically, the administrative procedures for reviewing a COPN request are established at Va. Code § 32.1-102.6. The regulations for the COPN program (12VAC5-220-10 *et seq.*) provide additional process direction for the review of COPN requests.

"BATCH" CYCLES

Va. Code § 32.1-102.2 provides the Board of Health (Board) authority to establish a "structured batching process" for the review of COPN requests. Batch review cycles are not to exceed 190 calendar days from the start of the review cycle.[1] The COPN regulations establish seven "batches," with each batch grouping like or similar project types (Table 1) and setting the start date for each batch review cycle. Each batch review cycle occurs twice a year with the exception of "Batch Group G," which is nursing home-related COPN requests, occurring six times per year.

Batch Group	General Description	Review Start
A	General hospitals, obstetrical services, neonatal special care services	Feb. 10
		Aug. 10
B	Open heart surgery, cardiac catheterization, ambulatory surgery centers / operating room additions, transplant services	Mar. 10
		Sep. 10
C	Psychiatric facilities, substance abuse treatment, mental retardation facilities	Apr. 10
		Oct. 10
D/F	Diagnostic imaging facilities/services, selected therapeutic facilities/services	May 10
		Nov. 10
E	Medical rehabilitation beds/services	Jun. 10
		Dec. 10
D/F	Diagnostic imaging facilities/services, selected therapeutic facilities/services	Jul. 10
		Jan. 10
G	Nursing home beds at retirement communities, bed relocations, miscellaneous expenditures by nursing homes	Jan. 10
		Mar. 10
		May 10
		Jul. 10
		Sep. 10
		Nov. 10

Table 1: Batch Groups

[1] *See* Va. Code § 32.1-102.6.

LETTER OF INTENT

Each COPN review, other than an expedited review, is initiated by an LOI. The LOI is a regulatory requirement[2] and is not addressed in the Code of Virginia. The LOI provides public notice of pending projects and affords an opportunity for submission of competing applications in the batch cycle. Prior to continuous document availability online and essentially universal access to the web by potential applicants, the LOI was also necessary to provide an opportunity for applicants to receive a copy of the application form and the relevant section of the State Medical Facilities Plan (SMFP).[3] LOIs are due at least 70 days before the start of the applicable batch review cycle, which is also 30 days before the applicable application due date. LOIs can also be submitted after the 70-day deadline for up to 10 days after the first LOI was submitted for review of the same or similar service, in the same planning district and the same batch cycle. LOIs are valid for up to a year from receipt by VDH. There is no fee or cost from VDH for the submission of an LOI.

APPLICATION SUBMISSION

Applications are due at least 40 days before the start of the applicable batch review cycle.[4] Forty days allows for the review of the application by DCOPN staff to determine if the application is complete and provide the applicant the opportunity to submit material needed to complete the application. Prior to July 1, 2020,[5] within the 40 days between receipt of the COPN application and the start of the COPN review cycle, 15 days were provided for DCOPN (and if applicable, the Regional Health Planning Agency (RHPA)), to determine if the application was complete, generate a list of missing material, and communicate that to the applicant.[6] The applicant then had 20 days to submit the listed missing material. Five additional days were provided for DCOPN (and if applicable, the RHPA) to review the additional material submitted by the applicant and determine if the application was then complete and generate a letter accepting the application for review in the batch review cycle.[7]

The amendments made by Chapter 1271 (2020 Acts of Assembly) requires that COPN applications be complete by the application submission deadline, with responses to all relevant sections of the application form. Complete applications should be able to support a decision without submitting additional supporting material.[8] As such, since July 1, 2020, there is no longer a need for a "completeness review" period within which the applicant has an opportunity to complete the application form after submission.

APPLICATION STAFF REVIEW

Public Comment

The requirement to conduct a public hearing was changed by Chapter 1271 (2020 Acts of Assembly) to only require public hearings for competing COPN reviews or upon request.[9] Public hearings, when required, are conducted by the RHPA in Health Planning Region II (HPR II)[10] and by DCOPN staff when conducted elsewhere.

Within 10 days of the start of the review cycle, notice of the review soliciting public comment must be posted. Receipt of public comment closes not later than 45 days from the date that the notice soliciting public comment is posted. At the latest, public comment, including those comments received via any public hearing, must be received by the 55th day of the review cycle.

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[2] *See* 12VAC5-220-180.
[3] Chapter 1271 (2020 Acts of Assembly) has renamed the State Medical Facilities Plan to the State Health Services Plan.
[4] *See* 12VAC5-220-180(C).
[5] The effective date of Chapter 1271 (2020 Acts of Assembly).
[6] *See* 12VAC5-220-190.
[7] Ibid.
[8] *See* Va. Code § 32.1-102.6(A).
[9] *See* Va. Code § 32.1-102.6(B).
[10] HPR II is in northern Virginia, and comprises the Alexandria, Arlington, Fairfax, Loudoun, and Prince William health districts.

Regional Health Planning Agency Review

Assuming the COPN request is for a project in HPR II, the RHPA has 60 days from the start of the cycle to conduct a public hearing, perform their own review and analysis, and conduct a meeting to vote to make a written recommendation to the Commissioner as to whether he should approve the request.[11] The RHPA review period runs concurrent with the public comment period and with the DCOPN staff review.

Division of Certificate of Public Need Staff Review

The DCOPN has 70 days starting with the start of the cycle to conduct a public hearing, perform their own review and analysis, and make a written recommendation to the Commissioner as to whether he should approve the request. The DCOPN review period runs concurrent with the public comment period and the RHPA review, if applicable.

COPN DECISION PROCESS

Within four days of the written recommendation from DCOPN—which is the 74th day of the review cycle—any person other than the applicant(s) seeking party status must file a petition for good cause, seeking an informal fact finding conference (IFFC). On the 75th day of the review cycle, a determination must be made as to the need for an IFFC.[12] The need for an IFFC is based on whether:

- there is a petition seeking good cause;
- either the RHPA or DCOPN has recommended denial of the COPN request; or
- the applicant does not agree to any aspect of the approval recommendation or the recommended conditions.

No Informal Fact Finding Conference

If it is determined there is no need for an IFFC, the record for the review closes on the 75th day of the review cycle.[13] A decision package is sent to the Commissioner for consideration, approximately seven days later. The Commissioner has up to 45 days,[14] from the close of the record on the 75th day of the review cycle, to consider the record and make a decision; assuming the Commissioner takes the entire 45 days to render a decision, this result in a total review cycle length of 120 days. By letter, the Commissioner may add 25 additional days,[15] extending the decision deadline and the review cycle to 145 days. After day 145, the request is deemed approved.[16] Typically, the Commissioner makes a decision within 14 days of receipt of the decision package, which is approximately the 96th day of the review cycle.

With an Informal Fact Finding Conference

If an IFFC is determined to be necessary, it will be held between the 80th and 90th day of the review cycle, on a date set when the project was accepted for review.[17] There are 30 days[18] allowed between the date of the IFFC and close of the record. Within those 30 days, the Adjudication Officer can review the documents and testimony presented at IFFC, and consolidate his notes. The court reporter produces and distributes a verbatim

[11] *See* Va. Code § 32.1-102.6(B).
[12] *See* Va. Code § 32.1-102.6(E).
[13] *See* Va. Code § 32.1-102.6(E)(5).
[14] *See* Va. Code § 32.1-102.6(E)(6).
[15] Ibid.
[16] *See* Va. Code § 32.1-102.6(E)(7).
[17] *See* Va. Code § 32.1-102.6(E)(1).
[18] *See* Va. Code § 32.1-102.6(E)(4).

transcript of the IFFC proceedings, generally within one to two weeks following the date of the IFFC. The applicant(s) develop and submit proposed findings of fact, followed by rebuttals in competing reviews.

After the close of the record, there is a 45-day period, with an additional 25 days allowed with notice[19] for the Adjudication Officer to develop a recommendation for the Commissioner based on the record as amended through the IFFC process. Within the same 45 days, the Commissioner must review:

- the recommendation of the RHPA (if applicable);
- the recommendation of DCOPN;
- the recommendation of the Adjudication Officer; and
- the record.

The Commissioner renders a decision on the COPN request to approve, deny or partially approve in accordance with the eight required considerations.[20] The 45-day period can be extended by the Commissioner to 70 days by providing written notice of an additional 25 days. If no decision is made by the end of the 25 extended days—which is day 190 of the review cycle—the COPN request is deemed approved.[21]

[19] *See* Va. Code § 32.1-102.6(E)(6).
[20] *See* Va. Code § 32.1-102.3.
[21] *See* Va. Code § 32.1-102.6(E)(7).

STAKEHOLDER INPUT

On August 5, 2020, an email was sent to over 100 COPN stakeholders, including medical care facilities, consultants, associations, and attorneys most active in participating in the COPN process. DCOPN requested feedback by September 4, 2020, on their ideas for how to reduce the average review time for COPN requests. Seven responses were received from two physician providers, two hospital systems, one provider association, one consultant and one attorney. Much of the feedback did not address the goal of reducing the average length of the review period, though it did contain good ideas for improving the COPN review process. The feedback that did address the time reduction goal is summarized in Appendix A.

The Adjudication Officer who conducts IFFCs for COPN reviews was contacted by email on July 21, 2020, for his feedback on draft recommendations, with a follow-up telephone call discussion on August 4, 2020. The Adjudication Officer's feedback was either incorporated into the recommendations or discussed at each step of the recommendation discussion.

EXPEDITED REVIEW

The expedited review process authorized by Va. Code § 32.1-102.2(A)(5) is addressed in 12VAC5-220-280 through 12VAC5-220-310. Project requests subject to expedited review:

- are not required to submit an LOI;
- are not subject to the batching process; and
- must be decided within 45 days of receipt of a complete application, unless it is determined the request is not eligible for expedited review, in which case the request is moved to the full review process.

Currently, very few[22] COPN requests undergo review through an expedited process. Only those projects with capital expenditures greater than $20,136,175 requested by persons other than a general hospital may be reviewed under the expedited review process.[23] Chapter 1271 (2020 Acts of Assembly, Special Session I) requires the State Health Services Plan Task Force (SHSP Task Force) to make recommendations to the Board whether certain projects should be subject to expedited review rather than the full review process.[24] Recommendations for a comprehensive State Health Services Plan (SHSP) are due from the SHSP Task Force on or before November 1, 2021.

Since projects subject to expedited review have a serious impact on the average length of a COPN review, certain project requests were included hypothetically as a proxy for calculating the overall average review period. Selected as the proxy requests were non-competing requests from existing medical care facilities that are beneath statutory capital expenditures threshold and that are increase existing capacity in an existing service by adding:

- medical/surgical beds;
- hospice beds;
- psychiatric beds;
- rehabilitation beds;
- cardiac catheterization laboratories;
- operating rooms;
- computed tomographic imaging machines;
- magnetic resonance imaging machines;
- positron emission tomography machines; and

[22] The current annual average is zero.
[23] *See* Va. Code § 32.1-102.2(A)(5).
[24] *See* Va. Code § 32.1-102.2:1(A).

- linear accelerators.

These project types were selected for the expedited review proxy because these projects tend to be less controversial since they are not included in a competitive review cycle, are likely to be approved, and are adding capacity to existing established services. Within a typical year, eight COPN requests of the type proposed for expedited review would be expected.

OPPORTUNITIES FOR REDUCTION IN REVIEW TIME

REDUCE TIME BETWEEN LETTER OF INTENT AND APPLICATION FROM 30 DAYS TO 14 DAYS (REDUCTION OF 16 DAYS)

This reduction of time can be achieved by amending the regulatory requirement[25] for an LOI so that an applicant's LOI is due to the Commissioner 14 days prior to application submission, rather than 30 days prior. With "near live" posting of the LOI to the VDH website, the public notice goal is served in real time. The online availability of application forms, regulations, and SMFP[26] criteria eliminates an applicant's need for delay between an LOI and an application. Fourteen days allows for one day for acknowledgement response and posting to the website and 13 days that provide public notice of pending project, an opportunity for competing applications in the batch cycle, and alerts to the community of the pending COPN request.

LOIs can currently be submitted at any time and are valid for up to a year from the date submitted. Since an LOI starts the clock for the calculation of average review time, reducing the time between LOI and application would result in either:

- batch cycles being eliminated, allowing submission of COPN requests at any time, impacting DCOPN's ability to manage workflow and competitive review; or
- LOIs only being accepted on predetermined due dates and being valid only for that specific batch cycle submitted.

Single date submission effectively eliminates the opportunity for responsive competitive LOIs. There are three potential solutions to address this issue. One option would be to allow LOI submission and acknowledgment at any time, with the LOI only being considered active and valid as of the due date. Another option would be to allow LOI submission at any time prior to the due date and for seven days after receipt of the first LOI for a like service, in the same planning district, in the same cycle. A final option would be to calculate the average length of a COPN review from the LOI due date regardless of when a specific LOI was received.

REDUCE TIME BETWEEN APPLICATION SUBMISSION AND CYCLE START FROM 40 DAYS TO 5 DAYS (REDUCTION OF 35 DAYS)

Chapter 1271 (2020 Acts of Assembly) amended Va. Code § 32.1-102.6(A) to provide that a completed application is to be submitted without need for additional material submission; essentially, a complete application is due by the established deadline for submission. If the application is determined to be complete, notice is sent to the applicant accepting the application for review in the review cycle scheduled to begin in 30 days. The DCOPN (and if applicable, the RHPA) can at this point—or at any other time in the review—request supplemental or clarifying material not considered necessary to "complete" the application. Va. Code § 32.1-102.6(A) retains the existing allowance of ten days for DCOPN (and if applicable, the RHPA) to review the applications for completeness. If the application is not complete, DCOPN is required to transmit:

- a list of missing material to the applicant within ten days of receipt of the application;
- a notice that the application is not complete and therefore not accepted for review; and

[25] Specifically, 12VAC5-220-180(A) would require amendment.

[26] As noted in Footnote 3, Chapter 1271 (2020 Acts of Assembly) has renamed the SMFP to the SHSP.

- the date by which a complete application must be received to be included the next appropriate batch review cycle.

The time from application submission could reasonably be reduced from 40 days to five days. Five days would be sufficient for review of the application for completeness and acceptance for review, or notification to the applicant if not accepted for review with a list of missing material. In reducing this period of time, policymakers may want to consider that there may be a possible need for an appeal process for applications not accepted for review and that the COPN application forms would require substantial revision. Current application forms for hospitals have been in use since at least 1992 and the nursing home application forms were last modified in 2010. By law, the applications may only require "data necessary for review of an application" and to reflect the "statutory requirements."[27] Clarification of the elements in the application form provides a better platform for the application to comply with submission of a complete application, but does not reduce the time required for a review. Policymakers should further be aware that adoption of the reduced time between application submission and cycle start requires amendment to Va. Code § 32.1-102.6(A) to reduce the time required for determination of completeness to four days, which in turn would require amendments to 12VAC5-220-180, 12VAC5-220-190, 12VAC5-220-200, and 12VAC5-220-230.

REDUCE TIME FOR STAFF REVIEW FROM 70 DAYS TO 65 DAYS (REDUCTION OF 5 DAYS)

Va. Code § 32.1-102.6 and 12VAC5-220-230 allows 60 days for the review of the application by the RHPA. The RHPA review involves:

- holding a public hearing when required;
- soliciting and receiving public comment outside the public hearing;
- evaluating the application against the 8 required considerations at Va. Code § 32.1-102.3 and any local criteria;
- producing a written evaluation and/or recommendation for the RHPA's board or designated committee of the RHPA's board; and
- conducting a meeting of the RHPA's board or designated committee of the RHPA's board to:
  - hear the recommendation;
  - hear a presentation from the applicant;
  - have an opportunity to question the applicant; and
  - vote on a recommendation to forward to the Commissioner.

Currently, Va. Code § 32.1-102.6(B) permits the RHPA to submit its recommendation to the Commissioner "within 10 calendar days after the completion of its 60-calendar-day review…." Running concurrent with and beyond the RHPA review, the DCOPN has 70 days to complete their review and make a recommendation. A complete review by DCOPN includes:

- receiving and incorporating the review and recommendation from the RHPA, if applicable;
- holding a public hearing when required if there is no RHPA;
- soliciting and receiving public comment outside the public hearing;
- evaluating the application against the 8 required considerations at Va. Code § 32.1-102.3; and
- producing a written evaluation and recommendation.

Public hearings are only required for competing reviews (approximately 19% of reviews) or by request of an elected local official, a member of the Virginia General Assembly, the Commissioner, the applicant or a member of the public. Given the variability of how a public hearing can be triggered, predicting the number of public hearings is difficult. Conduct of the public hearing, when required, occurs within the public comment period. Public comment must be solicited within 10 days of cycle start and end *no later than* 45 days from public notice, so at latest, 55 days from start of cycle.

The time from start of the review cycle to the completion of the DCOPN staff review could reasonably be reduced from 70 days to 65 days. The RHPA would need to be able to complete their required work within 60

[27] *See* Va. Code § 32.1-102.6(A).

days. The sole remaining RHPA[28] has reviewed an average of 14.8 COPN requests per year for the last five years, which is 31% of the COPN requests received by VDH. The RHPA reviews an average of more than one COPN request per month. Five days for DCOPN to incorporate the recommendations of the RHPA into the DCOPN report is likely adequate, and would allow the RHPA to complete their work by the sixtieth day of the cycle. The RHPA would have the same review period as they do currently, with the change being having to transmit their recommendation on the same day their review is complete instead of 10 days later. Available technology should ensure that is not a problem.

In reducing this period of time, policymakers may want to consider the RHPA's ability to meet a 60-day review schedule, especially since it would require transmission of the RHPA's board's recommendation within that same 60-day period. Further, Va. Code § 32.1-102.6 requires that the period for public comment begin no later than 10 days from the start of the review cycle and end not later than 45 days after the public notice soliciting public comment, which would be the 55th day of the review period; the maximum period of time of receipt of public comments is therefore 55 days. Requiring the RHPA to transmit its recommendations by the end of the 60-day review cycle requires amendment of Va. Code § 32.1-102.6(B) to remove the 10 days allowed for DCOPN's receipt of a recommendation from the RHPA. 12VAC5-220-230(A) and (B) would also need to be amended to:

- reduce the time allowed for DCOPN's receipt of a recommendation from the RHPA from 70 to 60 days;
- reduce the time allowed for DCOPN to complete their review and recommendation;
- eliminate the 10 days for transmission of the recommendation; and
- change the day by when DCOPN is to proceed as if the RHPA has recommended approval of the proposed project to the 61st day of the review cycle.

REDUCE TIME BETWEEN IFFC AND CLOSE OF THE RECORD FROM 30 DAYS TO 28 DAYS (REDUCTION OF 2 DAYS)

Va. Code § 32.1-102.6(E)(4) provides 30 days between the date of the IFFC and close of the record to allow the Adjudication Officer to review the documents and testimony presented at IFFC and consolidate his notes; the court reporter to produce and distribute the verbatim written record of the IFFC proceedings; and the parties to develop and submit proposed findings of fact followed by rebuttals in competing reviews. The time between the IFFC and record close may be reasonably reduced by two days, from 30 to 28 days. Reduction to less than 28 days may not allow adequate time for the applicants to adequately prepare and submit proposed findings of fact and rebuttals to any proposed findings submitted by competing applicants.

The current Adjudication Officer has expressed concerns with any reduction at this step. The court reporter has stated that the production of the verbatim written record of the IFFC can be accelerated to as little as four days, leaving adequate time for the applicant(s) to respond; however, such accelerated record production will be at an increased cost to VDH. If policymakers wish to make this reduction, it would require amendments to Va. Code § 32.1-102.6(E)(4) and 12VAC5-220-230(B).

REDUCE TIME BETWEEN CLOSE OF THE RECORD AND DECISION FROM 45 DAYS TO 40 DAYS (REDUCTION OF 5 DAYS)

Va. Code § 32.1-102.6(E)(6) provides 45 days for the Adjudication Officer to develop a recommendation for the Commissioner based on the record as amended through the IFFC process. Within this same 45 days, the Commissioner must review the recommendation of the RHPA (if applicable), the recommendation of DCOPN, the recommendation of the Adjudication Officer, and the record, and render a decision on the COPN request to approve, deny or partially approve the COPN request(s) in accordance with the 8 required considerations in Va. Code § 32.1-102.3. The 45-day period for the Commissioner's review can be extended

[28] Health Systems Agency of Northern Virginia.

by the Commissioner to 70 days by adding 25 days, with written notice from the Commissioner. If no decision is made by the end of the additional 25 days, the COPN request is deemed approved.

The time between the close of the record and the Commissioner's decision may be reasonably reduced by 5 days, from 45 days to 40 days. The current Adjudication Officer has concerns with any reduction at this step, though the availability of additional adjudication officers may facilitate this option, or facilitate even further reduce the time period. If policymakers wish to make this reduction, it would require amendments to Va. Code § 32.1-102.6(E)(6) and 12VAC5-220-230(C).

NO REASONABLE OPPORTUNITIES FOR TIME REDUCTION

There exists no reasonable opportunity to reduce the time after publication of DCOPN staff report available for good cause petition. Va. Code § 32.1-102.6(E)(3) currently allows four days. Further reduction would leave a time period that is too short for a potential petitioner to review and respond to the recommendations on a COPN request. Additionally, no reasonable opportunity exists to reduce the window in which an IFFC can be scheduled to be held. Va. Code § 32.1-102.6(E)(1) provides a 10-day window in which to schedule an IFFC. Scheduling for potentially multiple IFFCs with a single hearing officer in less than the ten day period, which would be between six and eight working days, is impractical.

ANALYSIS

There were a total of 234 COPN requests received for the period calendar year 2015 through calendar year 2019, excluding any projects deregulated from COPN by Chapter 1271 (2020 Acts of Assembly)[29]; this equates to an average of 47 COPN requests in a typical year. Of the 234 COPN requests, 39 would be reviewed under expedited review with the discussed expansion of that process (see "Expedited Review" above) and 195 would undergo full cycle review. Of the 195 requests expected to undergo full cycle review, 75 requests (38.5%) are expected to go to IFFC. Of the 75 COPN requests at IFFC, half of those requests can be expected to require the additional 25 days review allowable beyond the 45 days currently allowed after the close of the record[30] (Figure 1).

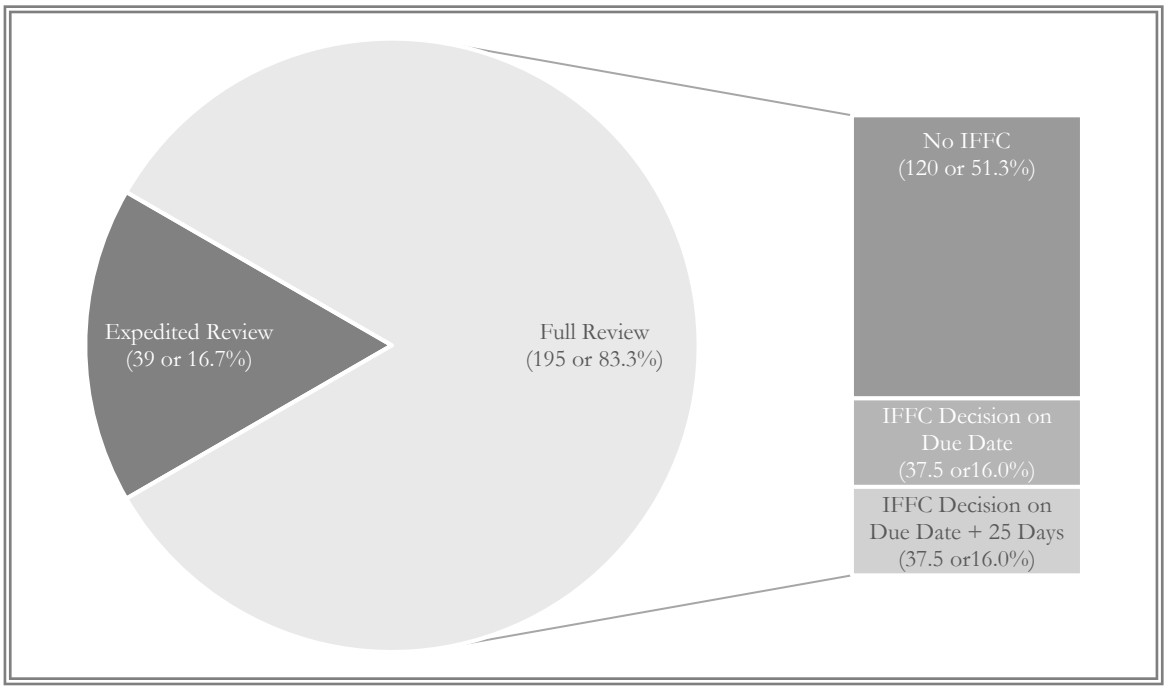

Figure 1: Number of COPN Requests by Review Type

The time allowed for each step—from receipt of the LOI to the decision—was calculated at the statutory limit maximum, tolling any time added at the applicant's request or consent[31], for each of four scenarios:

- requests that were required to go to IFFC, which had a total review time of 235 days;
- requests that were required to go to IFFC that also required the additional 25 days, which had a total review time of 250 days;
- requests that did not require IFFC, which had a total review time of 190 days; and
- requests that were subject to an expanded expedited review process, which had a total review time of 45 days.

[29] The deregulated projects are obstetrics, lithotripsy, nuclear medicine imaging, and linear accelerator based stereotactic radiotherapy/surgery.

[30] *See* Va. Code § 32.1-102.6(E)(6).

[31] Va. Code § 32.1-102.6(I) states, "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."

Using the five year (2015 – 2019) annual average of total decisions, a weighted average of projects that were required to go to IFFC, those that were not required to go to IFFC, and those that may be included in an expanded expedited review was used to calculate the *average* time of a COPN review. The time allowed for the various steps of a review were modified, until the average review time was at or below 120-days, using the formula below:

$$\frac{\left(\frac{1}{2}\times\ IFFC\ Projects \times Days\ for\ IFFC\right) + \left(\frac{1}{2}\times\ IFFC\ Projects \times (Days\ for\ IFFC + 25)\right) + (Expedited\ Projects \times Days\ for\ Expedited) + (Non\ IFFC\ Projects \times Days\ for\ No\ IFFC)}{Total\ Number\ of\ Projects}$$

Table 2 illustrates the time reductions for projects requiring an IFFC and *Table 3* illustrates the time reductions for projects not requiring an IFFC.

	LOI to App	App to Start	Start to Rpt	Rpt to IFFC	IFFC to Close	Close to Decision	+ 25 Days	Total
Current Days	30	40	70	20	20	45	25	260
Reduced Days	14	5	65	20	38	40	25	197
Days Saved	16	35	5	0	2	5	0	63

Table 2: COPN Projects Requiring IFFC

	LOI to App	App to Start	Start to Rpt	Rpt to Close	Close to Decision	Total
Current Days	30	40	70	5	45	190
Reduce to X Days	14	5	65	5	14	103
Days Saved	16	35	5	0	31	87

Table 3: COPN Projects That Do Not Require IFFC

Using the formula above, adoption of all the recommendations is expected to result in an average review time for COPN reviews of 119.5 calendar days (rounded to the nearest tenth decimal place), as measured from the deadline for receipt of the LOI to the Commissioner's decision.

$$\frac{\left(\frac{1}{2}\times 75 \times 172\right) + \left(\frac{1}{2}\times 75 \times (172 + 25)\right) + (39 \times 45) + (120 \times 103)}{234}$$

Assuming all recommendations are adopted, COPN requests heard at IFFC may take as long as 197 calendar days from receipt of the LOI to the decision. COPN requests that do not require a hearing at IFFC may take up to 103 calendar days from receipt of the LOI to the decision. The maximum review cycle, prior to the point a COPN request is deemed approved, will be 178 calendar days from the start of the cycle to the decision, 12 days less than the current 190 days. Currently, with the unexpanded list of projects eligible for expedited review, the maximum review time for a COPN request, absent a delay requested by the applicant, as measured from the deadline for receipt of the LOI to the Commissioner's decision, is 260 calendar days; the current average time for the review of a COPN request, from deadline for receipt of the LOI to a decision, disregarding any delays requested or authorized by the applicant, is 208 calendar days. Adoption of all the recommendations will reduce the maximum number of days to 197 calendar days, a reduction of 63 calendar days and the average review time to 119.5 days, a reduction of 88.5 calendar days.

NO. 1: REDUCE TIME BETWEEN LETTER OF INTENT AND APPLICATION

DCOPN recommends reducing the time between submission of the LOI and submission of the application from 30 to 14 days by amending 12VAC5-220-180(A) to:

- change the due date for submission of a LOI to 14 days before the due date for submission of an application,

- change the post submission deadline for submission of competing LOIs for the same or similar service in the same planning district or medical service area in the same cycle to seven days,
- add that an LOI must specify which specific batch review cycle the LOI is intended,
- change the time period within which the Department will acknowledge receipt and transmit the appropriate documents to the applicant to one day, and
- change the time at which point an LOI will be considered void to the start of appropriate batch cycle.

NO. 2: REDUCE TIME BETWEEN APPLICATION SUBMISSION AND CYCLE START

DCOPN recommends reducing the time between application submission and cycle start from 40 to five days by amending:

- Va. Code § 32.1-102.6(A) to reduce the time required for determination of completeness to five days;
- 12VAC5-220-180(C) to change the date for submission of a complete COPN application to five days prior to the first day of the review cycle;
- 12VAC5-220-190 to change the day that the department will notify the applicant if the submitted application is complete and accepted for review to four days after receipt of the application, and eliminate language providing for the submission of additional information to complete an application;
- 12VAC5-220-200 to change the title of the section from "One hundred ninety-day review cycle" to "One hundred seventy-eight-day review cycle," and change the REVIEW CYCLE Ends dates in the table from:
    - August 18 to August 6;
    - February 16 to February 4;
    - September 16 to September 4;
    - March 19 to March 7;
    - October 17 to October 5;
    - April 18 to April 6;
    - November 16 to November 4;
    - May 19 to May 7;
    - December 17 to December 5;
    - June 18 to June 6;
    - January 16 to January 4; and
    - July 18 to July 6;
- 12VAC5-220-230(A) to change the days between which the IFFC will be scheduled from between the 80th and 90th to between the 70th and 80th days; and
- 12VAC5-220-230(B) to change the period for determining if an application is complete to five days.

The regulatory amendments listed above are contingent on the success of the proposed amendment to Va. Code § 32.1-102.6(A)

NO. 3: REDUCE TIME FOR STAFF REVIEW

DCOPN recommends reducing review time allotted for its staff from 70 to 65 days by amending:

- Va. Code § 32.1-102.6(B) to reduce the maximum duration of a review cycle from 190 days to 178 days;
- Va. Code § 32.1-102.6(D) to reduce the maximum duration of a review cycle from 190 days to 178 days;
- Va. Code § 32.1-102.6(E) to reduce the maximum duration of a review cycle from 190 days to 178 days;
- 12VAC5-220-230(A) to reduce the time allowed for DCOPN's receipt of a recommendation from the RHPA from 70 days to 60 days, and to change the review cycle day by which DCOPN will complete their review and recommendation from the seventieth day to the sixty-fifth day; and
- 12VAC5-220-230(B) to eliminate the ten days for transmission of the recommendation and to change the day which DCOPN is to consider the recommendation to default to approval to the 61st day.

The regulatory amendments listed above are contingent on the success of the proposed amendments to Va. Code § 32.1-102.6(B), (D), and (E).

NO. 4: REDUCE TIME BETWEEN IFFC AND CLOSE OF THE RECORD

DCOPN recommends reducing the time between the IFFC and the close of the record from 30 days to 28 days by amending

- Va. Code § 32.1-102.6(E)(4) to change when the record closes from 30 calendar days to 28 calendar days, and
- 12VAC5-220-230(B) to change the day for the close of the record when an IFFC is held from 30 days to 28 days.

The regulatory amendment listed above is contingent on the success of the proposed amendments to Va. Code § 32.1-102.6(E)(4).

NO. 5: REDUCE TIME BETWEEN CLOSE OF THE RECORD AND DECISION

DCOPN recommends reducing the time between close of record and the Commissioner's decision from 45 days to 40 days by:

- Va. Code § 32.1-102.6(E)(6) to change the number of days post-closing of the record by which the Commissioner must make a decision on a COPN request or provide notice of deemed approval in 25 calendar days, absent a decision, from 45 calendar days to 40 calendar days;
- Va. Code § 32.1-102.6(E)(7) to change the number of days post-closing of the record by which, absent a decision by the Commissioner, a COPN request is deemed approved from 70 calendar days to 65 calendar days;
- 12VAC5-220-230(C) to change the number of days post-closing of the record by which:
    - the Commissioner must make a decision on a COPN request or provide notice of deemed approval in 25 calendar days, absent a decision, from 45 calendar days to 40 calendar days;
    - absent a decision by the Commissioner, a COPN request is deemed approved from 70 calendar days to 65 calendar days, and
    - absent a decision by the Commissioner, any person who has filed an application competing in the relevant batch review cycle or who has filed an application in response to the relevant request for applications may, prior to the application being deemed approved, petition for immediate injunctive relief from 45 calendar days to 40 calendar days.

The regulatory amendment listed above is contingent on the success of the proposed amendments to Va. Code § 32.1-102.6(E)(6) and (7).

NO. 6: EXPAND ELIGIBILITY FOR EXPEDITED REVIEW

DCOPN recommends expanding the types of COPN requests that are eligible for expedited review. This would require amendment of Va. Code § 32.1-102.2(A)(5) to include non-competing requests with capital expenditures below the statutory threshold from existing medical care facilities to increase capacity in an existing service through the addition of:

- medical/surgical beds;
- hospice beds;
- psychiatric beds;
- rehabilitation beds;
- cardiac catheterization laboratories;
- operating rooms;
- computed tomographic imaging machines;
- magnetic resonance imaging machines;
- positron emission tomography machines; and
- linear accelerators.

Provided that this proposed statutory amendment is successful, 12VAC5-220-280 would need to be amended to reflect the additional types of COPN requests eligible for expedited review.

Comment Summary	Response
Review of "uncontested" projects (4 comments)	
Remove uncontested and those projects that are rarely competing from the batch review cycle. Reduce the time for the review of such projects. Use an expanded expedited review process.	Will explore expanded use of expedited review. SHSP Task Force now tasked with exploring expanded use of expedited review 32.1-102.2:1(A). Removal from the batch cycle does not result in a means to shorten the average review time needed for an individual request.
Letter of Intent (6 comments)	
Maintain the 7 day response time for the LOI	The 7 day response time is for the DCOPN response. With near real time notice of receipt of LOIs DCOPN is unsure of the benefit of retaining the 7 day response period.
Address the fluid nature of LOI deadlines & 1 yr. life span of an LOI	Agreed. LOIs would need to be due on a single date and valid only for the cycle filed for.
Maintain 30 days between a LOI & submitting an application	Understand this preserves public notice & opportunity to competitively respond. With near real time posting of notice of receipt of LOIs and online availability of application forms and review criteria so that applicants can begin development of applications well in advance of LOI submission, DCOPN is unsure of the benefit of retaining the 30 day period.
Make LOI & application due same day	This would negate any utility provided by the LOI, rendering it useless.
Make LOI to Application 15 days	This only allows 8 days for application, if 7 days are allowed for response to LOI. If response to LOI is shortened this may be adequate.
Application Submission and Completeness Review (10 comments)	
Decrease the 70 days prior to the start of the review cycle to 30 days.	We will explore ways to accomplish this. Especially since applications must be complete on submission.
Seven comments to eliminate the time for completeness review.	32.1-102.6 now requires the application to be complete when submitted. Completeness review has been eliminated in practice, but not yet in Regulation.
Three comments to reduce the time for completeness to between 25 and 30 days.	32.1-102.6 now requires the application to be complete when submitted. Completeness review has been eliminated in practice, but not yet in Regulation.
Public Comment (1 comment)	
Decrease the solicitation and response time for public comment from 55 to 20 days	Public comment period runs concurrent with the review by the RHPA and the DCOPN.

Regional Health Planning Agency (4 comments)	
Require the RHPA review to be concurrent with the DCOPN review and/or be due at the end of public comment. Eliminate RHPA review time when no RHPA exists or add time when they do exist.	RHPA & DCOPN reviews are concurrent.
DCOPN Staff Review (2 comment)	
Staff Report could be produced within 15-30 days of the Public Hearing	Currently staff report is due by the 70th day. Since the Code allows 10 days to notice public comment, & 45 days for public comment, the staff report is within 15 days of close of public comment.
When there is no IFFC, reduce the current 50 day period for a decision by the Commissioner. (15-30 days of staff report)	When there is no IFFC the Commissioner's practice is to make a decision typically within 15-30 days of the DCOPN staff report now. Will consider formalizing this.
Informal Fact Finding Conference and Decision (8 comments)	
Determine if IFFC is needed at completeness review & schedule right away, not in 15 days.	The IFFC is scheduled at acceptance. The need for an IFFC is determined based on a denial recommendation on day 70 or receipt of a good cause petition based on the staff recommendation.
If IFFC needed, determine if there is good cause at completeness review & schedule right away, not in 15 days.	Good cause is based on factors not known until staff recommendations are complete.
Reduce time for IFFC to 10 days or 31-35 days	These comments were read to refer to the time from holding the IFFC to decision. Currently 100 days. The IFFC transcript is available in 10 working days, at an increased cost can be expedited to 4 work days. Parties are given time to submit proposed findings and rebuttal statements. Hearing officer and Commissioner need adequate time to evaluate the COPN request. Will consider opportunities to reduce the time allowed for IFFC to decision.
Close the record & Commissioner's decision in one week-10 days	IFFC transcript available in 10 work days, at an increased cost can be expedited to 4 work days. Adequate time is needed for the hearing officer & the Commissioner to carefully consider the record
Increase the amount of ALJ time available for COPN IFFCs.	Requires additional FTEs and funding. Will be considered based on need arising from changes adopted.
Toll the time of review delays requested by applicants from the calculation of average time of review.	Agreed.

APPENDIX B – COMPARISON OF CURRENT AND PROPOSED REVIEW SCHEDULES

Legal Authority	Current COPN Review Schedule	Event	Proposed COPN Review Schedule
12VAC5-220-180(A)	-70 days from cycle start	LOI due	-19 days from cycle start
12VAC5-220-180(A)	+7 days after LOI receipt	LOI response due	+1 day after LOI received
Va. Code § 32.1-102.6(A) 12VAC5-220-180(C)	-5 days from cycle start	Application due	-70 days from cycle start
Va. Code § 32.1-102.6(A) 12VAC5-220-190[32]	+10 days after application receipt	DCOPN determines completeness	+4 days after application receipt
Va. Code § 32.1-102.6(D) 12VAC5-220-230(A)	0 days from cycle start	Application accepted for review	0 days from cycle start
Va. Code § 32.1-102.6(D) 12VAC5-220-200	*Start of review cycle for complete applications*		
Va. Code § 32.1-102.6(B)	+0 – 10 days after cycle start	Public comment starts	+0 – 10 days after cycle start
Va. Code § 32.1-102.6(B)	+45 – 55 days after cycle start	Public comment ends	+45 – 55 days after cycle start
Va. Code § 32.1-102.6(B) 12VAC5-220-230(B)	+60 days after cycle start	RHPA review complete	+60 days after cycle start
	+70 days after cycle start	RHPA report due	
12VAC5-220-230(A)		DCOPN review complete and report due	+65 days after cycle start
Va. Code § 32.1-102.6(E)(2) 12VAC5-220-230(A)	+74 days after cycle start	Petition for good cause due	+69 days after cycle start
Va. Code § 32.1-102.6(E)(5)	+75 days after cycle start	Determination of need for IFFC (record closes if no IFFC needed)	+70 days after cycle start
Va. Code § 32.1-102.6(E)(1)	+80 – 90 days after cycle start	IFFC held	+70 – 80 days after cycle start

[32] This regulation was based on prior statutory language that was repealed by Chapter 1271 (2020 Acts of Assembly); efforts are underway to amend this regulation to conform to the new Va. Code § 32.1-102.6(A).

Legal Authority	Current COPN Review Schedule	Event	Proposed COPN Review Schedule
12VAC5-220-230(A)			
Va. Code § 32.1-102.6(E)(4)	+30 days after IFFC	Close of record after IFFC	+30 days after IFFC
Va. Code § 32.1-102.6(E)(6)	+45 days after record closes	Commissioner's decision due	+14 or +40 days after record closes
Va. Code § 32.1-102.6(E)(7)	+70 days after record closes	Deemed approval if no decision issued	+65 days after record closes
Va. Code § 32.1-102.6(D)	+190 days after cycle start	End of review cycle	+178 days after cycle start

Jurisdictional Comparison
Psychiatric Facilities, Beds, and Services

JDX	Has CON?	New Construction	Intro New Service (not in previous 12 mo)	New Beds	Psych beds to Nonpsych	Nonpsych beds to Psych	Cap Exp over $	Other	Notes
Alabama	Yes	Yes	Yes	Yes	No	Yes*			EXEMPT: HCF with at least 65% med/surg beds reallocate inpatient psychiatric beds to med/surg
Alaska	Yes	Yes	Yes	Yes	No	No	Yes, over $1M		
Arkansas	Yes	No	No	No	No	No	No		
Connecticut	Yes	Yes	Yes	Yes	No	No	No	Change of ownership, termination of service	EXEMPT: Until Jun. 30, 2026, increases in licensed bed capacity of mental health facilities if facility meets certain criteria
Delaware	Yes	Yes	No	Yes	Yes	Yes	Yes, over $5.8M		
Florida	Yes	No	No	No	No	No	No		
Georgia	Yes	Yes	Yes	Yes*	No	No	No		EXEMPT: Increases in bed capacity of up to 10 beds or 10% of capacity, whichever is greater, in any consecutive two-year period, in a hospital that has maintained an overall occupancy rate greater than 75% for the previous 12 month period
Hawaii	Yes	Yes	Yes	Yes*	Yes	Yes	Yes, over $4M		EXEMPT: Increases in bed capacity of up to 10 beds or 10% of capacity, whichever is greater, in any consecutive two-year period
Illinois	Yes	Yes	Yes	Yes	No	No	Yes, over $16.5M		
Indiana	Yes	Yes	No	Yes	No	No	Unknown		
Iowa	Yes	Yes	Yes	Yes	No	Yes	Yes, over $500K		
Kentucky	Yes	Yes	Yes	Yes	No	No	Yes, over $2.9M		
Louisiana	Yes	Yes	Yes	Yes	No	No	Unknown		
Maine	Yes	Yes	Yes	Yes	No	No	Yes, $1M-$10M*		Project type-specific capital expenditure threshold
Maryland	Yes	Yes	Yes	Yes			Yes, over $1.25M		
Massachusetts	Yes	Yes	Yes	Yes*	Yes	Yes	Yes		EXEMPT: Single or cumulative increases of 12 or fewer beds
Michigan	Yes	Yes	Yes	Yes	No	No	Yes	Bed relocation	
Mississippi	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Relocation of portion of facility; changes of ownership	
Missouri	Yes	No	No	No	No	No	No		
Montana	Yes	No	No	No	No	No	No		
Nebraska	Yes	No	No	No	No	No	No		
Nevada	Yes	Yes*	No	No	No	No	No		Construction capital expenditures must be greater than $2M
New Jersey	Yes	Yes	Yes	Yes	Yes*	Yes*	Yes, any amount		Specific conditions for bed conversion; see N.J.A.C 8:33-3.4
New York	Yes	No	No	No	No	No	No		
North Carolina	Yes	Yes	Yes	Yes	No	No	Yes, over $750K		
Ohio	Yes	No	No	No	No	No	No		
Oklahoma	Yes	Yes	Yes	Yes	No	No	Yes, over $500K		
Oregon	Yes	Yes	Yes	Yes	No	No	Yes, over $1M		
Rhode Island	Yes	Yes	Yes	Yes	No	No	Yes, over $5.9M		
South Carolina	Yes	Yes*	No	Yes*	No	No	No		SC in middle of COPN deregulation; hospital requirements to sunset on Jan. 1, 2027
Tennessee	Yes	Yes	Yes	Yes	No	No	Unspecified		Exceptions for Small Pop./Economic Distress
Vermont	Yes	Yes	Yes	Yes	No	No	Yes, over $1.5M		
Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes, over $15M		
Washington	Yes	Yes	Yes	Yes	No	No	Yes, over $1M		
West Virginia	Yes	Yes	Yes	Yes	No	No	Yes, over $100M		

Jurisdictional Comparison
Psychiatric Facilities, Beds, and Services

Washington, D.C.	Yes	Yes	Yes	Yes, with exem	No	No	Yes, over $3.5M	EXEMPT: From Dec. 18, 2001 to Dec. 17, 2002, any increase in psychiatric beds EXEMPT: On or after Oct. 20, 2005, any increase in psychiatric beds if expansion was request by Dept. of Mental Health in order to reduce services at Saint Elizabeths Hospital

Code of Virginia
Title 32.1. Health
Chapter 4. Health Care Planning

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:

"Application" means a prescribed format for the presentation of data and information deemed necessary by the Board to determine a public need for a project.

"Bad debt" means revenue amounts deemed uncollectable as determined after collection efforts based upon sound credit and collection policies.

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

"Charity care" means health care services delivered to a patient who has a family income at or below 200 percent of the federal poverty level and for which it was determined that no payment was expected (i) at the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person or (ii) at some time following the time the service was provided because the patient met the facility's criteria for the provision of care without charge due to the patient's status as an indigent person. "Charity care" does not include care provided for a fee subsequently deemed uncollectable as bad debt. For a nursing home as defined in § 32.1-123, "charity care" means care at a reduced rate to indigent persons.

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

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

"Project" means any action described in subsection B of § 32.1-102.1:3.

"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 Health Services 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 each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3;(ii) statistical information on the availability of each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3;and (iii) procedures, criteria, and standards for review of applications for projects for each type of medical care facility described in subsection A of § 32.1-102.1:3 and each type of project described in subsection B of § 32.1-102.1:3.

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;2004, c. 75;2007, c. 502;2008, c. 664;2009, cc. 67, 175, 813, 840;2011, cc. 92, 150;2012, cc. 476, 492, 507, 803, 835;2015, cc. 541, 542, 651;2017, cc. 458, 791;2020, c. 1271.

§ 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, stereotactic radiosurgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy, proton beam therapy, or other specialized service designated by the Board by regulation, any person shall register such purchase with the Commissioner and the appropriate regional health planning agency.

1999, cc. 899, 922;2000, c. 931;2009, c. 175.

§ 32.1-102.1:2. Certificate of public need required; registration of certain equipment and capital projects required

A. No person shall undertake a project described in subsection B of § 32.1-102.1:3 or regulations of the Board at or on behalf of a medical care facility described in subsection A of § 32.1-102.1:3 without first obtaining a certificate from the Commissioner.

B. No person shall acquire any replacement medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, proton beam therapy, or other specialized service designated by the Board by regulation without first registering such purchase with the Commissioner and the appropriate regional health planning agency. Such registration shall be made at least 30 calendar days prior to the date on which the person will become contractually obligated to acquire such medical equipment.

C. No general hospital shall make any capital expenditure of $5 million or more and no medical care facility other than a general hospital shall make any capital expenditure between $5 million and the amount established by the Board as the minimum capital expenditure by a medical care facility other than a general hospital for which a certificate is required pursuant to subdivision B 8 of § 32.1-102.1:3 without first registering such capital expenditure with the Commissioner pursuant to regulations of the Board. The amounts specified in this subsection shall be revised annually to reflect inflation using appropriate measures incorporating construction costs and medical inflation.

2020, c. 1271.

§ 32.1-102.1:3. Medical care facilities and projects for which a certificate is required

A. The following medical care facilities shall be subject to the provisions of this article:

1. Any facility licensed as a hospital, as defined in § 32.1-123;

2. Any hospital licensed as a provider by the Department of Behavioral Health and Developmental Services in accordance with Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title

37.2;

3. Any facility licensed as a nursing home, as defined in § 32.1-123;

4. Any intermediate care facility established primarily for the medical, psychiatric, or psychological treatment and rehabilitation of individuals with substance abuse licensed by the Department of Behavioral Health and Developmental Services in accordance with Article 2 (§ 37.2-403 et seq.) of Chapter 4 of Title 37.2;

5. Any intermediate care facility for individuals with developmental disabilities other than an intermediate care facility established for individuals with intellectual disability (ICF/IID) that has not more than 12 beds and is in an area identified as in need of residential services for individuals with intellectual disability in any plan of the Department of Behavioral Health and Developmental Services; and

6. Any specialized center or clinic or that portion of a physician's office developed for the provision of outpatient or ambulatory surgery, cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or proton beam therapy.

B. The following actions undertaken by or on behalf of a medical care facility described in subsection A shall constitute a project for which a certificate of public need is required pursuant to subsection A of § 32.1-102.1:2:

1. Establishment of a medical care facility described in subsection A;

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

3. Relocation of beds from an existing medical care facility described in subsection A to another existing medical care facility described in subsection A;

4. Addition of any new nursing home service at an existing medical care facility described in subsection A;

5. Introduction into an existing medical care facility described in subsection A of any cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), medical rehabilitation, neonatal special care, open heart surgery, positron emission tomographic (PET) scanning, psychiatric, organ or tissue transplant service, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, proton beam therapy, or substance abuse treatment when such medical care facility has not provided such service in the previous 12 months;

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

7. The addition by an existing medical care facility described in subsection A of any new medical equipment for the provision of cardiac catheterization, computed tomographic (CT) scanning, magnetic resonance imaging (MRI), open heart surgery, positron emission tomographic (PET)

scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or proton beam therapy, other than new medical equipment for the provision of such service added to replace existing medical equipment for the provision of such service;

8. Any capital expenditure of $15 million or more, not defined as reviewable in subdivisions 1 through 7, by or on behalf of a medical care facility described in subsection A other than a general hospital. The amounts specified in this subdivision shall be revised annually to reflect inflation using appropriate measures incorporating construction costs and medical inflation. Nothing in this subdivision shall be construed to modify or eliminate the reviewability of any project described in subdivisions 1 through 7 when undertaken by or on behalf of a general hospital; and

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

C. Notwithstanding the provisions of subsection A, any nursing home affiliated with a facility that, on January 1, 1982, and thereafter, (i) is operated as a nonprofit institution, (ii) is licensed jointly by the Department as a nursing home and by the Department of Social Services as an assisted living facility, and (iii) restricts admissions such that (a) admissions to the facility 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 of the facility are restricted to individuals defined as ambulatory by the Department of Social Services, and (c) admissions to the nursing home unit of the facility are restricted to those individuals who are residents of the assisted living facility unit of the facility shall not be subject to the requirements of this article.

D. Notwithstanding the provisions of subsection B, a certificate of public need shall not be required for the following actions undertaken by or on behalf of a medical care facility described in subsection A:

1. Relocation of up to 10 beds or 10 percent of the beds, whichever is less, (i) from one existing medical care facility described in subsection A to another existing medical care facility described in subsection A at the same site in any two-year period or (ii) in any three-year period, from one existing medical care facility described in subsection A licensed as a nursing home to any other existing medical care facility described in subsection A licensed as a nursing home that is owned or controlled by the same person and located either within the same planning district or within another planning district out of which, during or prior to that three-year period, at least 10 times that number of beds have been authorized by statute to be relocated from one or more medical care facilities described in subsection A located in that other planning district, and at least half of those beds have not been replaced; or

2. Use of up to 10 percent of beds as nursing home beds by a medical care facility described in subsection A licensed as a hospital, as provided in § 32.1-132.

E. The Department shall regularly review the types of medical care facilities subject to the provisions of this article and projects for which a certificate is required and provide to the Governor and the General Assembly, at least once every five years, a recommendation related to

the continued appropriateness of requiring such types of medical care facilities to be subject to the provisions of this article and such types of projects to be subject to the requirement of a certificate. In developing such recommendations, the Department shall consider, for each type of medical care facility and project, the following criteria:

1. The current and projected future availability of the specific type of medical care facility or project;

2. The current and projected future demand for the specific type of medical care facility or project;

3. The current and projected future rate of utilization of the specific type of medical care facility or project;

4. The current and projected future capacity of existing medical care facilities or projects of that specific type;

5. The anticipated impact of changes in population and demographics, reimbursement structures and rates, and technology on demand for and availability, utilization, and capacity of existing medical care facilities or projects of that specific type;

6. Existing quality, utilization, and other controls applicable to the specific type of medical care facility or project; and

7. Any risk to the health or well-being of the public resulting from inclusion of the specific type of medical care facility or project on such list.

2020, c. 1271.

§ 32.1-102.2. Regulations

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

1. Shall establish concise procedures for the prompt review of applications for certificates consistent with the provisions of this article which may include a structured batching process which incorporates, but is not limited to, authorization for the Commissioner to request proposals for certain projects. In any structured batching process established by the Board, applications, combined or separate, for computed tomographic (CT) scanning, magnetic resonance imaging (MRI), positron emission tomographic (PET) scanning, radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, and proton beam therapy shall be considered in the radiation therapy batch. A single application may be filed for a combination of (i) radiation therapy, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, and proton beam therapy and (ii) any or all of the computed tomographic (CT) scanning, magnetic resonance imaging (MRI), and positron emission tomographic (PET) scanning;

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. May establish a schedule of fees for applications for certificates or registration of a project to be applied to expenses for the administration and operation of the Certificate of Public Need Program;

5. Shall establish an expedited application and review process for any certificate for projects reviewable pursuant to subdivision B 8 of § 32.1-102.1:3. Regulations establishing the expedited application and review procedure shall include provisions for notice and opportunity for public comment on the application for a certificate, and criteria pursuant to which an application that would normally undergo the review process would instead undergo the full certificate of public need review process set forth in § 32.1-102.6;

6. Shall establish an exemption from the requirement for a certificate for a project involving a temporary increase in the total number of beds in an existing hospital or nursing home, including a temporary increase in the total number of beds resulting from the addition of beds at a temporary structure or satellite location operated by the hospital or nursing home, provided that the ability remains to safely staff services across the existing hospital or nursing home, (i) for a period of no more than the duration of the Commissioner's determination plus 30 days when the Commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds or (ii) for a period of no more than the duration of the emergency order entered pursuant to § 32.1-13 or 32.1-20 plus 30 days when the Board, pursuant to § 32.1-13, or the Commissioner, pursuant to § 32.1-20, has entered an emergency order for the purpose of suppressing a nuisance dangerous to public health or a communicable, contagious, or infectious disease or other danger to the public life and health; and

7. Shall require every medical care facility subject to the requirements of this article, other than a nursing home, that is not a medical care facility for which a certificate with conditions imposed pursuant to subsection B of § 32.1-102.4 has been issued and that provides charity care, as defined in § 32.1-102.1, to annually report the amount of charity care provided.

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

C. The Board shall also promulgate regulations authorizing the Commissioner to condition approval of a certificate on the agreement of the applicant to provide a level of charity care to indigent persons or accept patients requiring specialized care. Such regulations shall include a methodology and formulas for uniform application of, active measuring and monitoring of compliance with, and approval of alternative plans for satisfaction of such conditions. In addition, the Board's licensure regulations shall direct the Commissioner to condition the issuing or renewing of any license for any applicant whose certificate was approved upon such condition on whether such applicant has complied with any agreement to provide a level of charity care to

indigent persons or accept patients requiring specialized care. Except in the case of nursing homes, the value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

D. The Board shall also promulgate regulations to require the registration of a project; for introduction into an existing medical care facility of any new lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, obstetrical, or nuclear imaging services that the facility has never provided or has not provided in the previous 12 months; and for the addition by an existing medical care facility of any medical equipment for lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or nuclear imaging services. Replacement of existing equipment for lithotripsy, stereotactic radiosurgery, stereotactic radiotherapy other than radiotherapy performed using a linear accelerator or other medical equipment that uses concentrated doses of high-energy X-rays to perform external beam radiation therapy, or nuclear imaging services shall not require registration. Such regulations shall include provisions for (i) establishing the agreement of the applicant to provide a level of care in services or funds that matches the average percentage of indigent care provided in the appropriate health planning region and to participate in Medicaid at a reduced rate to indigents, (ii) obtaining accreditation from a nationally recognized accrediting organization approved by the Board for the purpose of quality assurance, and (iii) reporting utilization and other data required by the Board to monitor and evaluate effects on health planning and availability of health care services in the Commonwealth.

1982, c. 388; 1991, c. 561; 1993, c. 704; 1996, c. 1050;1999, cc. 899, 922, 926;2003, cc. 61, 72; 2007, c. 502;2009, c. 175;2017, c. 791;2019, cc. 136, 343, 839;2020, c. 1271;2022, cc. 712, 772.

§ 32.1-102.2:1. State Health Services Plan; Task Force

A. The Board shall appoint and convene a State Health Services Plan Task Force for the purpose of advising the Board on the content of the State Health Services Plan. The Task Force shall provide recommendations related to (i) periodic revisions to the State Health Services Plan, (ii) specific objective standards of review for each type of medical care facility or project type for which a certificate of public need is required, (iii) project types that are generally noncontested and present limited health planning impacts, (iv) whether certain projects should be subject to expedited review rather than the full review process, and (v) improvements in the certificate of public need process. All such recommendations shall be developed in accordance with an analytical framework established by the Commissioner that includes a specific evaluation of whether State Health Services Plan standards are consistent with the goals of (a) meeting the health care needs of the indigent and uninsured citizens of the Commonwealth, (b) protecting the public health and safety of the citizens of the Commonwealth, (c) promoting the teaching missions of academic medical centers and private teaching hospitals, and (d) ensuring the availability of essential health care services in the Commonwealth, and are aligned with the goals and metrics of the Commonwealth's State Health Improvement Plan.

B. The Task Force shall consist of no fewer than 19 individuals appointed by the Commissioner who are broadly representative of the interests of all residents of the Commonwealth and of the

various geographic regions, including two representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Health Care Association, and physicians or administrators representing teaching hospitals affiliated with a public institution of higher education; one representative each of the Virginia Association of Health Plans, the Virginia Association of Free and Charitable Clinics, the Virginia Community Healthcare Association, LeadingAge Virginia, a company that is self-insured or full-insured for health coverage, a nonprofit organization located in the Commonwealth that engages in addressing access to health coverage for low-income individuals, and a rural locality recognized as a medically underserved area; one individual with experience in health facilities planning; and such other individuals as the Commissioner determines is appropriate.

C. The powers and duties of the Task Force shall be:

1. To develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan for adoption by the Board that includes (i) specific formulas for projecting need for medical care facilities and services subject to the requirement to obtain a certificate of public need, (ii) current statistical information on the availability of medical care facilities and services, (iii) objective criteria and standards for review of applications for projects for medical care facilities and services, and (iv) methodologies for integrating the goals and metrics of the State Health Improvement Plan established by the Commissioner into the criteria and standards for review. Criteria and standards for review included in the State Health Services Plan shall take into account current data on drive times, utilization, availability of competing services, and patient choice within and among localities included in the health planning district or region; changes and availability of new technology; and other relevant factors identified by the Task Force. The State Health Services Plan shall also include 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 planning district or region as a whole;

2. To engage the services of private consultants or request the Department to contract with any private organization for professional and technical assistance and advice or other services to assist the Task Force in carrying out its duties and functions pursuant to this section. The Task Force may also solicit the input of experts with professional competence in the subject matter of the State Health Services Plan, including (i) representatives of licensed health care providers or health care provider organizations owning or operating licensed health facilities and (ii) representatives of organizations concerned with health care consumers and the purchasers and payers of health care services; and

3. To review annually and, if necessary, develop recommendations for revisions to each section of the State Health Services Plan on a rotating schedule defined by the Task Force at least every two years following the last date of adoption by the Board.

D. The Task Force shall exercise its powers and carry out its duties to ensure:

1. The availability and accessibility of quality health services at a reasonable cost and within a reasonable geographic proximity for all people in the Commonwealth, competitive markets, and patient choice;

2. Appropriate differential consideration of the health care needs of residents in rural localities in ways that do not compromise the quality and affordability of health care services for those residents;

3. Elimination of barriers to access to care and introduction and availability of new technologies and care delivery models that result in greater integration and coordination of care, reduction in costs, and improvements in quality; and

4. Compliance with the goals of the State Health Services Plan and improvement in population health.

E. The Department shall post on its website information regarding the process by which the State Health Services Plan is created and the process by which the Department determines whether a proposed project complies with the State Health Services Plan on its website.

2008, c. 501;2009, c. 175;2020, c. 1271.

§ 32.1-102.3. Demonstration of public need required; criteria for determining need

A. 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 Health Services 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. In cases in which a provision of the State Health Services Plan has been previously set aside by the Commissioner and relevant amendments to the Plan have not yet taken effect, the Commissioner's decision shall be consistent with the applicable portions of the State Health Services Plan that have not been set aside and the remaining considerations in subsection B.

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

1. The extent to which the proposed project will provide or increase access to health care services for people in the area to be served and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;

2. The extent to which the proposed project will meet the needs of people in the area to be served, as demonstrated by each of the following: (i) the level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served; (ii) the availability of reasonable alternatives to the proposed project that would meet the needs of people in the area to be served in a less costly, more efficient, or more effective manner; (iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;(iv) any costs and benefits of the proposed project; (v) the financial accessibility of the proposed project to people in the area to be served, including indigent people; and (vi) at the discretion of the Commissioner, any other factors as may be

relevant to the determination of public need for a proposed project;

3. The extent to which the proposed project is consistent with the State Health Services Plan;

4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

6. The feasibility of the proposed project, including the financial benefits of the proposed project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate; and

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care services for citizens of the Commonwealth, including indigent or underserved populations.

1982, c. 388; 1984, c. 740; 1993, c. 704; 1999, c. 926;2000, c. 931;2004, cc. 71, 95;2008, c. 292; 2009, c. 175;2020, cc. 227, 558, 1271.

§ 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 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.

1982, c. 659; 1993, cc. 957, 993; 2008, c. 857;2009, c. 175;2011, c. 155.

§ 32.1-102.3:1.1. Continuing care retirement communities accessing medical assistance

A. A nursing facility in Planning District 8 in a continuing care retirement community registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2, which is not already certified for participation in the Medical Assistance Program, may be certified for participation in the Medical Assistance Program, without regard to any condition of a certificate of public need, so long as:

1. The nursing facility is no longer operating under an open admissions period;

2. Any residents who qualify and receive medical assistance under the state program must have been residents of the continuing care retirement community for at least three years;

3. Not more than 25 percent of the nursing home beds of the facility, or 15 nursing home beds, whichever is fewer, may be occupied by individuals receiving benefits at any given time; and

4. Any resident who qualifies for and receives medical assistance under the state program in a continuing care retirement community nursing facility must have first exhausted any refundable entrance fee paid on the resident's behalf, as defined in § 38.2-4900, as a result of expenditures for that resident's care in the continuing care retirement community.

B. Nothing in this section shall alter the conditions of a continuing care retirement community's participation in the Medical Assistance Program if that continuing care retirement community was certified for participation prior to July 1, 2010.

For the purposes of this section, "open admissions period" means a time during which a facility may take admissions directly into its nursing home beds without the signing of a standard contract.

2008, c. 857;2011, c. 155;2019, cc. 299, 384.

§ 32.1-102.3:2. Certificates of public need; applications 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 shall approve, authorize or accept applications for the issuance of any certificate of public need pursuant to this article only in response to Requests for Applications (RFAs) 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, except as provided in § 32.1-102.3:7.

B. The Board shall adopt regulations establishing standards for the approval and issuance of Requests for Applications by the Commissioner. 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 and the Department of Medical Assistance Services. RFAs shall be 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 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 RFA, the Board 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 14 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 RFA, 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, applications for continuing care retirement community nursing home bed projects shall be accepted by the Commissioner 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 20 percent of the continuing care retirement community's total number of beds that are not nursing home beds or 60 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 20 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 may approve an initial certificate of public need for nursing home beds in a continuing care retirement community not to exceed the lesser of 60 beds or 20 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 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 20 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 20 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 (a) 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 30 days, (b) 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 30 days but who requires nursing home care due to change in health status since admission to the continuing care retirement community, (c) 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, (d) a person who is an employee or a member of the board of trustees or board of directors of the continuing care retirement community, (e) a person who is a family member of an employee or a member of the board of trustees or board of directors of the continuing care retirement community, or (f) a person who is an accredited practitioner of the religious organization or denomination with which the continuing care retirement community is affiliated.

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 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 (a) take into account the sound financial management of the facility, including existing reserves, and the reasonable requirements of lenders and (b) 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 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;2009, c. 175;2012, c. 492;2013, cc. 433, 515.

§ 32.1-102.3:7. Application for transfer of nursing facility beds

A. Notwithstanding the provisions of § 32.1-102.3:2, the Commissioner shall accept and may approve applications for the transfer of nursing facility beds from one planning district to another planning district when no Request for Applications has been issued in cases in which the applicant can demonstrate (i) there is a shortage of nursing facility beds in the planning district to which beds are proposed to be transferred, (ii) the number of nursing facility beds in the planning district from which beds are proposed to be moved exceeds the need for such beds, (iii) the proposed transfer of nursing facility beds would not result in creation of a need for additional beds in the planning district from which the beds are proposed to be transferred, and (iv) the nursing facility beds proposed to be transferred will be made available to individuals in need of nursing facility services in the planning district to which they are proposed to be transferred without regard to the source of payment for such services.

B. Applications received pursuant to this section shall be subject to the provisions of this article governing review of applications for certificate of public need.

2013, c. 515.

§ 32.1-102.3:8. Application for an open admission period for a continuing care retirement community

A. Notwithstanding the provisions of § 32.1-102.3:2, the Commissioner shall accept and may approve applications for a two-year or three-year open admission period for a continuing care retirement community nursing facility approved as part of an initial certificate of public need pursuant to subsection E of § 32.1-102.3:2.

B. Any person seeking an open admission period pursuant to subsection A shall provide written notice of the proposed open admission period to all nursing facilities located within the planning district. The Commissioner shall accept public comment on an application for an open admission period pursuant to subsection A for a period of 14 days following submission of the application.

2013, c. 515.

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

A. The Commissioner may, in accordance with regulations of the Board, condition issuance of a certificate on compliance with a schedule for the completion of the proposed project and a maximum capital expenditure amount for the proposed project. The approved schedule and maximum capital expenditure for a proposed project shall be issued together with the certificate.

The approved 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. 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.

The Commissioner shall monitor each project to determine its progress and compliance with the approved schedule and with the maximum capital expenditure, and may revoke the certificate for (i) lack of substantial and continuing progress toward completion of the project in accordance with the schedule or (ii) expenditures in excess of the approved maximum capital expenditure for the project.

Any person willfully violating conditions imposed pursuant to this subsection shall be subject to a civil penalty of up to $100 per violation per day until the date of completion of the project which shall be collected by the Commissioner and paid into the Literary Fund.

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

B. The Commissioner shall, pursuant to the regulations of the Board, condition the approval of a certificate upon the agreement of the applicant to provide care to individuals who are eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), and 10 U.S.C. § 1071 et seq. In addition, the Commissioner shall condition the approval of a certificate upon the agreement of the applicant to (i) provide a specified level of charity care to indigent persons or accept patients requiring specialized care, (ii) facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area, or (iii) all of the above. Except in the case of nursing homes, the value of charity care provided to individuals pursuant to this subsection shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

Every certificate holder shall develop a financial assistance policy that includes specific eligibility criteria and procedures for applying for charity care, which shall be provided to a patient at the time of admission or discharge or at the time services are provided, included with any billing statements sent to uninsured patients, posted conspicuously in public areas of the medical care facility for which the certificate was issued and posted on a website maintained by the certificate holder.

The certificate holder shall annually provide documentation to the Department demonstrating that the certificate holder has satisfied the conditions of the certificate, including documentation of the amount of charity care provided to patients. If the certificate holder is unable or fails to satisfy the conditions of a certificate, the Department may approve alternative methods to satisfy the conditions pursuant to a plan of compliance, which shall identify a timeframe within which the certificate holder will satisfy the conditions of the certificate, and identify how the certificate holder will satisfy the conditions of the certificate, which may include (a) making direct payments to an organization authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, (b) making direct payments to a private nonprofit foundation that funds basic insurance coverage for indigents

authorized under a memorandum of understanding with the Department to receive contributions satisfying conditions of a certificate, or (c) other documented efforts or initiatives to provide primary or specialized care to underserved populations. In cases in which the certificate holder holds more than one certificate with conditions pursuant to this subsection, and the certificate holder is unable to satisfy the conditions of one certificate, such plan of compliance may provide for satisfaction of the conditions on that certificate by providing care at a reduced rate to indigent individuals in excess of the amount required by another certificate issued to the same holder, in an amount approved by the Department provided such care is offered at the same facility. Nothing in the preceding sentence shall prohibit the satisfaction of conditions of more than one certificate among various affiliated facilities or certificates subject to a system-wide or all-inclusive charity care condition established by the Commissioner. In determining whether the certificate holder has met the conditions of the certificate pursuant to a plan of compliance, only such actions undertaken after issuance of the conditioned certificate shall be counted towards satisfaction of conditions.

Any person 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 which shall be collected by the Commissioner and paid into the Literary Fund. For the purpose of determining the amount of a civil penalty imposed pursuant to this subsection, the date on which the person began providing services in accordance with the original certificate shall be the date from which the period of noncompliance shall be calculated.

C. The Commissioner shall (i) review every certificate of public need upon which conditions were imposed pursuant to subsection B at least once every three years to determine whether such conditions continue to be appropriate or should be revised and (ii) notify each certificate holder of his conclusions regarding (a) the appropriateness of conditions imposed on the certificate and whether such conditions should be revised and (b) the process by which the certificate holder may request amendments to conditions imposed on a certificate in accordance with subsection D.

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

E. In determining whether conditions imposed on a certificate of public need pursuant to subsection B are appropriate for the purposes of subsection C or should be amended in response to a request submitted pursuant to subsection D, the Commissioner shall consider any changes in the circumstances of the certificate holder resulting from changes in the financing or delivery of health care services, including changes to the Commonwealth's program of medical assistance services, and any other specific circumstances of the certificate holder.

1982, c. 388; 1991, c. 561; 1992, c. 682; 1993, cc. 668, 704; 1998, c. 794;2009, cc. 175, 711, 796, 877;2013, c. 460;2017, cc. 768, 791;2019, c. 839;2020, c. 1271.

§ 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 regional health planning agency if a regional health planning agency has been designated for that region. Such application shall be filed in accordance with procedures established by the Department. An application submitted for review shall be considered complete when all relevant sections of the application form have responses. The applicant shall provide sufficient information to prove public need for the requested project exists without the addition of supplemental or supporting material at a later date. The Department shall ensure that only data necessary for review of an application is required to be submitted and that the application reflects statutory requirements. Nothing in this section shall prevent the Department from seeking, at its discretion, additional information from the applicant or other sources.

Within 10 calendar days of the date on which the document is received, the Department and the appropriate regional health planning agency, if a regional health planning agency has been designated, 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. If no regional health planning agency is designated for the health planning region in which the project will be located, no filing with a regional health planning agency is required and the Department shall determine if the application is complete and notify the applicant, if the application is not complete, of the information needed to complete the application.

At least 30 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 regional health planning agency, if a regional health planning agency has been designated, 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. If no regional health planning agency is designated for the health planning region in which the acquisition will take place, no notification to a regional health planning agency shall be required.

B. For projects proposed in health planning regions with regional planning agencies, the appropriate regional health planning agency shall (i) review each completed application for a certificate within 60 calendar days of the day that 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; (ii) within 10 calendar days following the start of the review cycle, solicit public comment on such application by posting notice of such application and a summary of the proposed project on a website maintained by the Department; such notice shall include information about how comments may be submitted to the regional health planning agency and the date on which the public comment period shall expire, which shall be no later than 45 calendar days following the date of the public notice; and (iii) in the case of competing applications or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public, 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. Prior to any required public hearing, the regional health planning agency shall notify the local governing bodies in the planning district.

At least nine days prior to the public hearing, the regional 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 the project is proposed to be located. The regional health planning agency shall consider the comments of the local governing bodies in the planning district and all other public comments in making its decision. Such comments shall be part of the record. In no case shall a regional health planning agency hold more than two meetings on any application, one of which shall be the public hearing required pursuant to clause (iii), if any, conducted by the board of the regional 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 regional 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 regional health planning agency staff, any information in a regional health planning agency staff report, or comments by those voting members of the regional health planning agency board; however, such opportunity shall not increase the 60-calendar-day period designated herein for the regional health planning agency's review unless the applicant or applicants request a specific extension of the regional health planning agency's review period.

The regional health planning agency shall submit its recommendations on each application and its reasons therefor to the Department within 10 calendar days after the completion of its 60-calendar-day review or such other period in accordance with the applicant's request for extension.

If the regional health planning agency has not completed its review within the specified 60 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 10 calendar days after the completion of its review, the Department shall, on the eleventh calendar day after the expiration of the regional health planning agency's review period, proceed as though the regional health planning agency has recommended project approval without conditions or revision.

If no regional health planning agency has been designated for a region, the Department shall (a) within 10 calendar days following the start of the review cycle, solicit public comment on such application by posting notice of such application and a summary of the proposed project on a website maintained by the Department; such notice shall include such information about how comments may be submitted to the Department and the date on which the public comment period shall expire, which shall be no later than 45 calendar days following the date of the public notice, and (b) in the case of competing applications or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public, hold one hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city. Prior to any required hearing, the Department shall notify the local governing bodies in the planning district in which the project is proposed. At least nine days prior to the public hearing, the Department shall cause notice of the public hearing to be published in a newspaper of general circulation in the county or city where the project is proposed to be located. The Department shall consider the comments of the local governing bodies in the planning district and all other public comments in making its decision. Such comments shall be part of the record.

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 clause (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 regional health planning agency, if a regional health planning agency has been designated.

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 40 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 (§ 2.2-4000 et seq.) except for those parts of the determination process for which timelines and specifications are delineated in subsection E. Further, if an informal fact-finding conference is determined to be necessary by the Department or is requested by a person seeking good cause standing, 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, and the relevant health planning agency.

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, no later than four days after the Department has completed its review and submitted its recommendation on an application and has transmitted the same to the applicants and to persons who have, prior to the issuance of the report, requested a copy in writing, shall notify the Commissioner, all applicants, and the regional health planning agency, in writing and under oath, stating the grounds for good cause and providing the factual basis therefor.

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 30 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 C of § 2.2-4021 notwithstanding, if a determination whether a public need exists for a project is not made by the Commissioner within 45 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 25 calendar days after expiration of such 45-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 25-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise impact the effectiveness of this section.

7. In any case when a determination whether a public need exists for a project is not made by the Commissioner within 70 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 45 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 § 2.2-4030, 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 § 2.2-4030 shall apply.

F. Deemed approvals shall be construed as the Commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 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" means 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.

J. This section shall not apply to applications for certificates for projects defined in subdivision A 8 of § 32.1-102.1:3. Such projects shall be subject to an expedited application and review process developed by the Board in regulation pursuant to subdivision A 2 of § 32.1-102.2.

1982, c. 388; 1984, c. 740; 1991, c. 561; 1999, cc. 899, 922;2000, c. 931;2004, cc. 71, 95;2005, c. 404;2009, c. 175;2010, c. 646;2020, c. 1271.

§ 32.1-102.6:1. Revocation of a certificate

The Commissioner shall revoke a certificate of public need for:

1. Failure to comply with the requirements of subsection A of § 32.1-102.4 regarding schedules for completion of a project or maximum capital expenditures for a project; or

2. Willfully or recklessly misrepresented intentions or facts in obtaining a certificate.

2020, c. 1271.

§ 32.1-102.8. Enjoining project undertaken without certificate or registration

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 that is constructed, undertaken, or commenced without a certificate or registration required by this article or to enjoin the admission of patients to the project or to enjoin the provision of services through the project.

1982, c. 388; 2020, c. 1271.

§ 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 or registration grounds for refusing to issue license

Commencing any project without a certificate or registration required by this article shall constitute grounds for refusing to issue a license for such project. Persons commencing any project without a certificate or registration as required by this article shall be subject to the penalties set forth in §§ 32.1-27 and 32.1-27.1.

1982, c. 388; 2009, c. 175;2020, c. 1271.

§ 32.1-102.11. Application of article

A. Every project of an existing or proposed medical care facility described in subsection A of § 32.1-102.1:3 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 B 6 of § 32.1-102.1:3, 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 (§ 2.2-4000 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; 2020, c. 1271.

Virginia Administrative Code
Title 12. Health
Agency 5. Department of Health
Chapter 220. Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations

Part I. Definitions

12VAC5-220-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Acquisition" means an expenditure of $600,000 or more that changes the ownership of a medical care facility. It shall also include the donation or lease of a medical care facility. An acquisition of a medical care facility shall not include a capital expenditure involving the purchase of stock. See 12VAC5-220-120.

"Amendment" means any modification to an application that is made following the public hearing and prior to the issuance of a certificate and includes those factors that constitute a significant change as defined in this chapter. An amendment shall not include a modification to an application that serves to reduce the scope of a project.

"Applicant" means the owner of an existing medical care facility or the sponsor of a proposed medical care facility project submitting an application for a certificate of public need.

"Application" means a prescribed format for the presentation of data and information deemed necessary by the board to determine a public need for a medical care facility project.

"Application fees" means fees required for a project application and application for a significant change. Fees shall not exceed the lesser of 1.0% of the proposed capital expenditure or cost increase for the project or $20,000.

"Board" means the State Board of Health.

"Capital expenditure" means any expenditure by or in behalf of a medical care facility that, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance. Such expenditure shall also include a series of related expenditures during a 12-month period or a financial obligation or a series of related financial obligations made during a 12-month period by or in behalf of a medical care facility. Capital expenditures need not be made by a medical care facility so long as they are made in behalf of a medical care facility by any person. See definition of "person."

"Certificate of public need" means a document that legally authorizes a medical care facility project as defined herein and which is issued by the commissioner to the owner of such project.

"Clinical health service" means a single diagnostic, therapeutic, rehabilitative, preventive or palliative procedure as defined in § 32.1-102.1 of the Code of Virginia.

"Commissioner" means the State Health Commissioner who has authority to make a

determination respecting the issuance or revocation of a certificate.

"Competing applications" means applications for the same or similar services and facilities that are proposed for the same planning district or medical service area and which are in the same review cycle. See 12VAC5-220-220.

"Completion" means conclusion of construction activities necessary for substantial performance of the contract.

"Construction" means the building of a new medical facility or the expansion, remodeling, or alteration of an existing medical care facility.

"Construction, initiation of" means that a project shall be considered under construction for the purpose of certificate extension determinations upon the presentation of evidence by the owner of: (i) a signed construction contract; (ii) the completion of short term financing and a commitment for long term (permanent) financing when applicable; (iii) the completion of predevelopment site work; and (iv) the completion of building foundations.

"Date of issuance" means the date of the commissioner's decision awarding a certificate of public need.

"Department" means the Virginia Department of Health.

"Designated medically underserved areas" means (i) areas designated as medically underserved areas pursuant to § 32.1-122.5 of the Code of Virginia; (ii) federally designated Medically Underserved Areas (MUA); or (iii) federally designated Health Professional Shortage Areas (HPSA).

"Ex parte" means any meeting that takes place between (i) any person acting in behalf of the applicant or holder of a certificate of public need or any person opposed to the issuance or in favor of the revocation of a certificate of public need and (ii) any person who has authority in the department to make a decision respecting the issuance or revocation of a certificate of public need for which the department has not provided 10 days written notification to opposing parties of the time and place of such meeting. An ex parte contact shall not include a meeting between the persons identified in (i) and staff of the department.

"Gamma knife surgery" means stereotactic radiosurgery, where stereotactic radiosurgery is the noninvasive therapeutic procedure performed by directing radiant energy beams from any source at a treatment target in the head to produce tissue destruction. See definition of "project."

"Health planning region" means a contiguous geographical area of the Commonwealth as defined in § 32.1-102.1 of the Code of Virginia.

"Informal fact-finding conference" means a conference held pursuant to § 2.2-4019 of the Code of Virginia.

"Inpatient beds" means accommodations within a medical care facility with continuous support services (such as food, laundry, housekeeping) and staff to provide health or health-related services to patients who generally remain in the medical care facility in excess of 24 hours. Such accommodations are known by varying nomenclatures including but not limited to: nursing beds,

intensive care beds, minimal or self care beds, isolation beds, hospice beds, observation beds equipped and staffed for overnight use, and obstetric, medical, surgical, psychiatric, substance abuse, medical rehabilitation and pediatric beds, including pediatric bassinets and incubators. Bassinets and incubators in a maternity department and beds located in labor or birthing rooms, recovery rooms, emergency rooms, preparation or anesthesia inductor rooms, diagnostic or treatment procedures rooms, or on-call staff rooms are excluded from this definition.

"Medical care facility" means any institution, place, building, or agency as defined in § 32.1-102.1 of the Code of Virginia.

"Medical service area" means the geographic territory from which at least 75% of patients come or are expected to come to existing or proposed medical care facilities, the delineation of which is based on such factors as population characteristics, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed medical care facilities.

"Modernization" means the alteration, repair, remodeling, replacement or renovation of an existing medical care facility or any part thereto, including that which is incident to the initial and subsequent installation of equipment in a medical care facility. See definition of "construction."

"Operating expenditure" means any expenditure by or in behalf of a medical care facility that, under generally accepted accounting principles, is properly chargeable as an expense of operation and maintenance and is not a capital expenditure.

"Operator" means any person having designated responsibility and legal authority from the owner to administer and manage a medical care facility. See definition of "owner."

"Other plans" means any plan(s) which is formally adopted by an official state agency or regional health planning agency and which provides for the orderly planning and development of medical care facilities and services and which is not otherwise defined in this chapter.

"Owner" means any person who has legal responsibility and authority to construct, renovate or equip or otherwise control a medical care facility as defined herein.

"Person" means an individual, corporation, partnership, association or any other legal entity, whether governmental or private. Such person may also include the following:

1. The applicant for a certificate of public need;

2. The regional health planning agency for the health planning region in which the proposed project is to be located;

3. Any resident of the geographic area served or to be served by the applicant;

4. Any person who regularly uses health care facilities within the geographic area served or to be served by the applicant;

5. Any facility or health maintenance organization (HMO) established under § 38.2-4300 et seq. of the Code of Virginia that is located in the health planning region in which the project is

proposed and that provides services similar to the services of the medical care facility project under review;

6. Third party payors who provide health care insurance or prepaid coverage to 5.0% or more patients in the health planning region in which the project is proposed to be located; and

7. Any agency that reviews or establishes rates for health care facilities.

"Physician's office" means a place, owned or operated by a licensed physician or group of physicians practicing in any legal form whatsoever, which is designed and equipped solely for the provision of fundamental medical care whether diagnostic, therapeutic, rehabilitative, preventive or palliative to ambulatory patients and which does not participate in cost-based or facility reimbursement from third party health insurance programs or prepaid medical service plans excluding pharmaceuticals and other supplies administered in the office. See definition of "medical care facility."

"Planning district" means a contiguous area within the boundaries established by the Department of Housing and Community Development as set forth in § 15.2-4202 of the Code of Virginia, except that for purposes of this chapter, Planning District 23 shall be divided into two planning districts: Planning District 20, consisting of the counties of Isle of Wight and Southampton and the cities of Chesapeake, Franklin, Norfolk, Portsmouth, Suffolk and Virginia Beach; and Planning District 21, consisting of the counties of James City and York and the cities of Hampton, Newport News, Poquoson and Williamsburg.

"Predevelopment site work" means any preliminary activity directed towards preparation of the site prior to the completion of the building foundations. This includes, but is not limited to, soil testing, clearing, grading, extension of utilities and power lines to the site.

"Primary medical care services" means first-contact, whole-person medical and health services delivered by broadly trained, generalist physicians, nurses and other professionals, intended to include, without limitation, obstetrics/gynecology, family practice, internal medicine and pediatrics.

"Progress" means actions that are required in a given period of time to complete a project for which a certificate of public need has been issued. See 12VAC5-220-450, Demonstration of progress.

"Project" means any plan or proposal as defined in § 32.1-102.1 of the Code of Virginia that is subject to Certificate of Public Need approval.

"Public hearing" means a proceeding conducted by a regional health planning agency at which an applicant for a certificate of public need and members of the public may present oral or written testimony in support or opposition to the application that is the subject of the proceeding and for which a verbatim record is made. See subsection A of 12VAC5-220-230.

"Regional health plan" means the regional plan adopted by the regional health planning agency board.

"Regional health planning agency" means the regional agency as defined in § 32.1-102.1 of the

Code of Virginia.

"Rural" means territory, population, and housing units that are classified as "rural" by the Bureau of the Census of the United States Department of Commerce, Economics and Statistics Administration.

"Schedule for completion" means the timetable that identifies the major activities required to complete a project as identified by the applicant and set forth on the certificate of public need. The timetable is used by the commissioner to evaluate the applicant's progress in completing an approved project.

"Significant change" means any alteration, modification or adjustment to a reviewable project for which a certificate of public need has been issued or requested following the public hearing which:

1. Changes the site;

2. Increases the capital expenditure amount authorized by the commissioner on the certificate of public need issued for the project by 10% or more;

3. Changes the service(s) proposed to be offered;

4. Extends the schedule for completion of the project beyond three years (36 months) from the date of certificate issuance or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater. See 12VAC5-220-440 and 12VAC5-220-450.

"Standard review process" means the process utilized in the review of all certificate of public need requests with the exception of:

1. Certain bed relocations as specified in 12VAC5-220-280;

2. Certain projects that involve an increase in the number of beds in which nursing facility or extended care services are provided as specified in 12VAC5-220-325.

"State Medical Facilities Plan" means the planning document as contained in Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, used to make medical care facilities and services needs decisions.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 1.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997; Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 20, Issue 26, eff. September 27, 2004; Volume 24, Issue 11, eff. March 5, 2008.

Part II. General Information

12VAC5-220-20. Authority for regulations.

The Virginia Medical Care Facilities Certificate of Public Need Law, which is codified as Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, requires the owners or sponsors of medical care facility projects to secure a certificate of public need from the State Health Commissioner prior to initiating such projects. Sections 32.1-102.2 and 32.1-12 of the Code of Virginia direct the Board of Health to promulgate and prescribe such rules and regulations as are deemed necessary to effectuate the purposes of this statute.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-30. Purpose of chapter.

The board has promulgated this chapter to set forth an orderly administrative process for making public need decisions.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-40. Administration of chapter.

This chapter is administered by the following:

1. The Board of Health is the governing body of the Virginia Department of Health. The Board of Health has the authority to promulgate and prescribe such rules and regulations as it deems necessary to effectuate the purposes of the Act.

2. The State Health Commissioner is the executive officer of the Virginia Department of Health. The commissioner is the designated decision maker in the process of determining public need under the Act.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.3, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-50. Public meetings and public hearings.

All meetings and hearings convened to consider any certificate of public need application shall be open to the public in accordance with the provisions of the Virginia Freedom of Information Act (§ 2.1-340 et seq.) of the Code of Virginia.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.4, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-60. Official records.

Written information including staff evaluations and reports and correspondence developed or utilized or received by the commissioner during the review of a medical care facility project shall become part of the official project record maintained by the Department of Health and shall be made available to the applicant, competing applicant and review bodies. Other persons may obtain a copy of the project record upon request. All records are subject to the Virginia Freedom of Information Act.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.5, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-70. Application of chapter.

This chapter has general applicability throughout the Commonwealth. The requirements of the Virginia Administrative Process Act (§ 9-6.14:1 et seq.) of the Code of Virginia apply to their promulgation.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.6, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-80. Powers and procedures of chapter not exclusive.

The commissioner and the board reserve the right to authorize any procedure for the enforcement of this chapter that is not inconsistent with the provisions set forth herein and the provisions of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.7, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-90. Annual report.

Pursuant to § 32.1-102.12 of the Code of Virginia, the commissioner shall annually report to the Governor and the General Assembly on the status of Virginia's certificate of public need program.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 2.8, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003; Volume 26, Issue 2, eff. November 1, 2009.

Part III. Mandatory Requirements

12VAC5-220-100. Requirements for reviewable medical care facility projects; exceptions.

A. Prior to initiating a reviewable medical care facility project the owner or sponsor shall obtain a certificate of public need from the commissioner. In the case of an acquisition of an existing medical care facility, the notification requirement set forth in 12VAC5-220-120 shall be met.

B. Projects involving a temporary increase in the total number of beds in an existing hospital or nursing home shall be exempt from the requirement for a certificate, for a period of no more than 30 days, if the commissioner has determined that a natural or man-made disaster has caused the evacuation of a hospital or nursing home and that a public health emergency exists due to a shortage of hospital or nursing home beds.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 3.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; Volume 35, Issue 24, eff. August 23, 2019.

12VAC5-220-105. Requirements for registration of the replacement of existing medical equipment.

Within 30 days of any person contracting to make, or otherwise legally obligating to make, a capital expenditure for the replacement of medical equipment or otherwise acquiring

replacement medical equipment for the provision of services listed in subdivision 7 of the definition of "project" in 12VAC5-220-10, the person shall register in writing such equipment replacement with the commissioner and the appropriate regional health planning agency. Such registration shall be made on forms provided by the department. The registration shall identify the specific unit of equipment to be replaced and the estimated capital cost of the replacement and shall include documentation that the equipment to be replaced has previously been authorized or exempted as allowed by law.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 14, Issue 12, eff. April 2, 1998; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003; Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-110. Requirements for registration of certain capital expenditures.

A. At least 30 days before any person contracts to make or is otherwise legally obligated to make a capital expenditure by or on behalf of a medical care facility as defined in this chapter that has not been previously authorized by the commissioner, such expenditure shall be registered in writing with the commissioner. The threshold amount for capital expenditure project registration shall be determined using the formula contained in subsection B of this section.

B. The threshold contained in subsection A of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

A x (1+B)

where:

A = the capital expenditure threshold amount for the previous year

and

B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

C. The format for registration shall include information concerning the purpose of such expenditure and projected impact that the expenditure will have upon the charges for services. For purposes of registration, the owner shall include any person making the affected capital expenditure. See definition of "project."

D. Annually, the department shall (i) publish the threshold amount in the General Notices section of the Virginia Register of Regulations and (ii) post the threshold amount on its website.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 3.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; Volume 13, Issue 7, eff. January 24, 1997; Volume 24, Issue 11, eff. March 5, 2008; Volume 25, Issue 1, eff. October 15, 2008; Volume 26, Issue 2, eff. November 1, 2009; Volume 26, Issue 26, eff. September 30, 2010; Volume 27, Issue 24, eff. September 1, 2011; Volume 30, Issue 8, eff. February 3, 2014.

12VAC5-220-120. Requirement for notification of proposed acquisition of medical care facility.

At least 30 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 provide written notification to the commissioner and the regional health planning agency that serves the area in which the facility is located. Such notification shall identify the name of the medical care facility, the current and proposed owner, the cost of the acquisition, the services to be added or deleted, the number of beds to be added or deleted, and the projected impact that the cost of the acquisition will have upon the charges of the services to be provided in the medical care facility. The commissioner shall provide written notification to the person who plans to acquire the medical care facility within 30 days of receipt of the required notification. If the commissioner finds that a reviewable clinical health service or beds are 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. If such certificate is required, an application will be considered under an appropriate batch group which will be identified at the time of written notification by the commissioner to the applicant for such acquisition.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 3.3, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-130. Significant change limitation.

No significant change in a project for which a certificate of public need has been issued shall be made without prior written approval of the commissioner. Such request for a significant change shall be made in writing by the owner to the commissioner with a copy to the appropriate regional health planning agency. The owner shall also submit the application fee to the department if applicable at the time the written request is made. The written request shall identify the nature and purpose of the change. The regional health planning agency shall review the proposed change and notify the commissioner of its recommendation with respect to the change within 30 days from receipt of the request by both the department and the regional health planning agency. Failure of the regional health planning agency to notify the commissioner within the 30-day period shall constitute a recommendation of approval. The commissioner shall act on the significant change request within 35 days of receipt. A public

hearing during the review of a proposed significant change request is not required unless determined necessary by the commissioner. The commissioner shall not approve a significant change in cost for a project which exceeds the authorized capital expenditure by more than 20%. The commissioner shall not extend the schedule for completion of a project beyond three years from the date of issuance of the certificate or beyond the time period approved by the commissioner at the date of certificate issuance, whichever is greater, except when delays in completion of a project have been caused by events beyond the control of the owner and the owner has made substantial and continuing progress toward completion of the project.

Exception: The commissioner may approve a significant change in cost for an approved project that exceeds the authorized capital expenditure by more than 20%, provided the applicant has demonstrated that the cost increases are reasonable and necessary under all the circumstances and do not result from any material expansion for the project as approved.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 3.4, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; Volume 24, Issue 11, eff. March 5, 2008.

12VAC5-220-140. Requirements for health maintenance organizations (HMO).

An HMO must obtain a certificate of public need prior to initiating a project. Such HMO must also adhere to the requirements for the acquisition of medical care facilities if appropriate. See definition of "project" and 12VAC5-220-10.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 3.5, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-155. Requirements for the reporting of charity care.

Every medical care facility subject to the requirements of Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia, other than a nursing home, that is not a medical care facility for which a certificate with conditions imposed pursuant to § 32.1-102.4 F of the Code of Virginia has been issued and that provides charity care, as defined in § 32.1-102.1 of the Code of Virginia, shall annually report to the commissioner the amount of charity care provided.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 35, Issue 24, eff. August 23, 2019.

Part IV. Determination of Public Need (Required Considerations)

12VAC5-220-160. Required considerations.

In determining whether a public need exists for a proposed project, the applicable requirements of § 32.1-102.2:1 of the Code of Virginia will be considered.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 4.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; Volume 19, Issue 8, eff. February 29, 2003; Volume 20, Issue 26, eff. September 27, 2004; Volume 25, Issue 1, eff. October 15, 2008; Volume 26, Issue 2, eff. November 1, 2009.

Part V. Standard Review Process

12VAC5-220-170. Preconsultation.

Each regional health planning agency and the department shall provide upon request advice and assistance concerning community health resources needs to potential applicants. Such advice and assistance shall be advisory only and shall not be a commitment on behalf of the regional health planning agency or the commissioner.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-180. Application forms.

A. Letter of intent. An applicant shall file a letter of intent with the commissioner to request appropriate application forms, and submit a copy of that letter to the appropriate regional health planning agency, by the later of (i) 30 days prior to the submission of an application for a project included within a particular batch group or (ii) 10 days after the first letter of intent is filed for a project within a particular batch group for the same or similar services and facilities which are proposed for the same planning district or medical service area. The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. A letter of intent filed with the department shall be considered void one year after the date of receipt of such letter. (See

12VAC5-220-310 C.)

B. Application fees. The department shall collect application fees for applications that request a certificate of public need. The fee required for an application shall be 1.0% of the proposed expenditure for the project, but not less than $1,000 and no more than $20,000.

No application will be deemed to be complete for review until the required application fee is paid. (See 12VAC5-220-310 C.)

C. Filing application forms. Applications must be submitted at least 40 days prior to the first day of a scheduled review cycle to be considered for review in the same cycle. In order to verify the date of the department's and the appropriate regional health planning agency's receipt of the application, the applicant shall transmit the document electronically, or prepare in triplicate two copies to be submitted to the department and one copy to be submitted to the appropriate regional health planning agency and sent by certified mail or a delivery service, return receipt requested, or by hand, with a signed receipt to be provided. No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency. (See 12VAC5-220-200.)

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-190. Review for completeness.

The applicant shall be notified by the department within 15 days following receipt of the application if additional information is required to complete the application or the application is complete as submitted. No application shall be reviewed until the department has determined that it is complete. To be complete, all questions must be answered to the satisfaction of the commissioner and all requested documents supplied, when applicable and the application fee submitted. Additional information required to complete an application shall be submitted to the department and the appropriate regional health planning agency at least five days prior to the first day of a review cycle to be considered complete for review in the same review cycle. (See 12VAC5-220-200.)

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.3, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-200. One hundred ninety-day review cycle.

A. The department shall review the following groups of completed applications in accordance with the following 190-day scheduled review cycles and the following descriptions of projects within each group, except as provided for in 12VAC5-220-220.

BATCH GROUP	GENERAL DESCRIPTION	REVIEW CYCLE	
		Begins	Ends
A	General Hospitals/Obstetrical Services/Neonatal Special Care Services	Feb. 10 Aug. 10	Aug. 18 Feb. 16
B	Open Heart Surgery/Cardiac Catheterization/Ambulatory Surgery Centers/Operating Room Additions/Transplant Services	Mar. 10 Sep. 10	Sep. 16 Mar. 19
C	Psychiatric Facilities/Substance Abuse Treatment/Mental Retardation Facilities	Apr. 10 Oct. 10	Oct. 17 Apr. 18
D/F	Diagnostic Imaging Facilities/Services Selected Therapeutic Facilities/Services	May 10 Nov. 10	Nov. 16 May 19
E	Medical Rehabilitation Beds/Services	June 10 Dec. 10	Dec. 17 Jun. 18
D/F	Selected Therapeutic Facilities/Services Diagnostic Imaging Facilities/Services	July 10 Jan. 10	Jan. 16 Jul. 18
G	Nursing Home Beds at Retirement Communities/Bed Relocations/Miscellaneous Expenditures by Nursing Homes	Jan. 10 Mar. 10 May 10 July 10 Sep. 10 Nov. 10	Jul. 18 Sep. 16 Nov. 16 Jan. 16 Mar. 19 May 19

Batch Group A includes:

1. The establishment of a general hospital.

2. An increase in the total number of general acute care beds in an existing or authorized general hospital.

3. The relocation at the same site of 10 general hospital beds or 10% of the general hospital beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period if such relocation involves a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section (see 12VAC5-220-280).

4. The introduction into an existing medical care facility of any new neonatal special care or obstetrical services that the facility has not provided in the previous 12 months.

5. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category included in Batch Groups B through G, by or in behalf of a general hospital.

Batch Group B includes:

1. The establishment of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.

2. An increase in the total number of operating rooms in an existing medical care facility or establishment of operating rooms in a new facility.

3. The introduction into an existing medical care facility of any new cardiac catheterization, open heart surgery, or organ or tissue transplant services that the facility has not provided in the previous 12 months.

4. The addition by an existing medical care facility of any medical equipment for the provision of cardiac catheterization.

5. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a specialized center, clinic, or portion of a physician's office developed for the provision of outpatient or ambulatory surgery or cardiac catheterization services.

6. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Group A or Batch Groups C through G, by or in behalf of a medical care facility, that is primarily related to the provision of surgery, cardiac catheterization, open heart surgery, or organ or tissue transplant services.

Batch Group C includes:

1. The establishment of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

2. An increase in the total number of beds in an existing or authorized mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

3. An increase in the total number of mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds in an existing or authorized medical care facility that is not a dedicated mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facility.

4. The relocation at the same site of 10 mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds or 10% of the mental hospital, psychiatric hospital, substance abuse treatment and rehabilitation, or mental retardation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period if such relocation involves a capital expenditure with an expenditure

exceeding the threshold amount as determined using the formula contained in subsection B of this section (see 12VAC5-220-280).

5. The introduction into an existing medical care facility of any new psychiatric or substance abuse treatment service that the facility has not provided in the previous 12 months.

6. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A and B or Batch Groups D/F through G, by or in behalf of a mental hospital, psychiatric hospital, intermediate care facility established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts, or mental retardation facilities.

7. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A and B or Batch Groups D/F through G, by or in behalf of a medical care facility, which is primarily related to the provision of mental health, psychiatric, substance abuse treatment or rehabilitation, or mental retardation services.

Batch Group D/F includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, except for the purpose of nuclear cardiac imaging.

2. The introduction into an existing medical care facility of any new computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging services, except for the purpose of nuclear cardiac imaging that the facility has not provided in the previous 12 months.

3. The addition by an existing medical care facility of any equipment for the provision of computed tomography (CT), magnetic resonance imaging (MRI), magnetic source imaging (MSI), or positron emission tomographic (PET) scanning.

4. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A, B, C, E, and G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic (PET) scanning, or nuclear medicine imaging, except that portion of a physician's office dedicated to providing nuclear cardiac imaging.

5. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A, B, C, E, and G, by or in behalf of a medical care facility, which is primarily related to the provision of computed tomographic (CT) scanning, magnetic resonance imaging (MRI), magnetic source imaging (MSI), positron emission tomographic

(PET) scanning, or nuclear medicine imaging, except for the purpose of nuclear cardiac imaging.

Batch Group E includes:

1. The establishment of a medical rehabilitation hospital.

2. An increase in the total number of beds in an existing or authorized medical rehabilitation hospital.

3. An increase in the total number of medical rehabilitation beds in an existing or authorized medical care facility that is not a dedicated medical rehabilitation hospital.

4. The relocation at the same site of 10 medical rehabilitation beds or 10% of the medical rehabilitation beds of a medical care facility, whichever is less, from one existing physical facility to another in any two-year period, if such relocation involves a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section (see 12VAC5-220-280).

5. The introduction into an existing medical care facility of any new medical rehabilitation service that the facility has not provided in the previous 12 months.

6. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A, B, C, D/F, and G, by or in behalf of a medical rehabilitation hospital.

7. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A, B, C, D/F, and G, by or in behalf of a medical care facility, that is primarily related to the provision of medical rehabilitation services.

Batch Group D/F includes:

1. The establishment of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

2. Introduction into an existing medical care facility of any new gamma knife surgery, lithotripsy, or radiation therapy services that the facility has not provided in the previous 12 months.

3. The addition by an existing medical care facility of any medical equipment for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

4. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project in Batch Groups A, B, C, E, and G, by or in behalf of a specialized center, clinic, or that portion of a physician's office developed for the provision of gamma knife surgery, lithotripsy, or radiation therapy.

5. Any capital expenditure with an expenditure exceeding the threshold amount as determined

using the formula contained in subsection B of this section and not defined as a project in Batch Groups A, B, C, E, and G, by or in behalf of a medical care facility, which is primarily related to the provision of gamma knife surgery, lithotripsy, or radiation therapy.

Batch Group G includes:

1. The establishment of a nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

2. The establishment of a nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds within a planning district.

3. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility of a continuing care retirement community by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

4. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility that does not involve an increase in the number of nursing home facility beds within a planning district.

5. The relocation at the same site of 10 nursing home, intermediate care facility, or extended care facility beds or 10% of the nursing home, intermediate care facility, or extended care facility beds of a medical care facility, whichever is less, from one physical facility to another in any two-year period, if such relocation involves a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section (see 12VAC5-220-280).

6. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A through D/F, by or in behalf of a nursing home, intermediate care facility, or extended care facility, which does not increase the total number of beds of the facility.

7. Any capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section and not defined as a project category in Batch Groups A through D/F, by or in behalf of a medical care facility, that is primarily related to the provision of nursing home, intermediate care, or extended care services, and does not increase the number of beds of the facility.

B. The capital expenditure threshold referenced in subsection A of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

A x (1+B)

where:

A = the capital expenditure threshold amount for the previous year

and

B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

C. Annually, the department shall (i) publish the threshold amount in the General Notices section of the Virginia Register of Regulations and (ii) post the threshold amount on its website.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.4, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; Volume 13, Issue 7, eff. January 24, 1997; Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 20, Issue 2, eff. November 5, 2003; Volume 24, Issue 11, eff. March 5, 2008; Volume 25, Issue 1, eff. October 15, 2008; Volume 26, Issue 2, eff. November 1, 2009; Volume 26, Issue 26, eff. September 30, 2010; Volume 27, Issue 24, eff. September 1, 2011; Volume 30, Issue 8, eff. February 3, 2014.

12VAC5-220-210. Requests for application (RFA).

The commissioner may request the submission of applications for his consideration which address a specific need for services and facilities as identified in the State Medical Facilities Plan. The department shall give notice of such RFA in a newspaper of general circulation in the locality or the planning district where the specific services or facility is requested. Such notice shall be published at least 120 days prior to the first day of the appropriate review cycle for the type of project being requested. A written copy of an RFA shall also be available upon request from the department and the regional health planning agency in the appropriate geographic area. The process for adoption of an RFA by the commissioner for projects listed in § 32.1-102.3:2 A, B, and C of the Code of Virginia are set forth in 12VAC5-220-335.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.5, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997; Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-220. Consideration of applications.

Applications for the same or similar services which are proposed for the same planning district or medical service area shall be considered as competing applications by the commissioner. The

commissioner shall determine whether an application is competing and shall provide written notification to the competing applicants and the regional health planning agency. The commissioner may, upon the request of an applicant, waive the review schedule requirements of 12VAC5-220-200 in the case of a documented emergency or in cases where, as of the deadline for filing a letter of intent for the otherwise applicable cycle, there are no competing applicants, and the applicant who has filed a letter of intent for a particular project proposes to combine the intended project with another related project for which an application will be filed in a subsequent batch group.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.6, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-230. Review of complete application.

A. Review cycle. At the close of the work day on the tenth day of the month, the department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications, including the date for any informal fact-finding conference that may be held between the eightieth and ninetieth day of the review cycle. The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, the comments of local governing bodies in the health planning district, all other public comments, or comments by those voting in completing its review and recommendation by the sixtieth day of the cycle. By the seventieth day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicants and other appropriate persons. By the seventy-fifth day of the review cycle, the department shall transmit to the applicant and the appropriate other persons its determination whether an informal fact-finding conference is necessary.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person seeking to be made a party to the case for good cause. Any person seeking to be made a party to the case for good cause shall file, no later than four days after the department has completed its review and recommendation of an application and has transmitted the same to the applicants and to persons who have prior to the issuance of the report requested a copy in writing, written notification with the commissioner, applicants and other competing applicants, and regional health planning agency stating the grounds for good cause and providing the factual basis therefor under oath.

For purposes of this section, "good cause" means 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 regional health planning agency. See § 32.1-102.6 of the Code of Virginia.

B. Time period for review. The review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12VAC5-220-200. If the application is not determined to be complete for the applicable batch cycle within 40 calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

If the regional health planning agency has not completed its review by the sixtieth day of the review cycle, or such other period in accordance with the applicant's request for extension, and submitted its recommendation within 10 calendar days after the completion of its review, the department shall, on the eleventh day after expiration of the regional health planning agency's review period, proceed as if the regional health planning agency has recommended approval of the proposed project.

In any case in which an informal fact-finding conference is not held, the project 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 that an informal fact-finding conference is not necessary. See 12VAC5 220-230 A.

In any case in which an informal fact-finding conference is held, a date shall be established for closing of the record that shall not be more than 30 calendar days after the date for holding the informal fact-finding conference.

C. Determination by the commissioner. If a determination whether a public need exists for a project is not made by the commissioner within 45 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 applications of each shall be deemed approved 25 calendar days after the expiration of such 45-calendar-day period, unless the receipt of recommendations from the person performing as hearing officer permits the commissioner to issue his case decision within that 25-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise impact the effectiveness of this section.

In any case when a determination whether a public need exists for a project is not made by the commissioner within 70 calendar days after closing of the record, the application shall be deemed approved and a certificate shall be granted.

If a determination whether a public need for a project exists is not made by the commissioner within 45 calendar days of the closing of the record, any person who has filed an application competing in the relevant batch review cycle or who has filed an application in response to the relevant Request for Applications issued pursuant to 12VAC5-220-355 may, prior to the application being deemed approved, petition for immediate injunctive relief pursuant to § 2.2-4030 of the Code of Virginia, naming as respondents the commissioner and all parties to the case. During the pendency of proceeding, no applications shall be deemed to be approved. In such a proceeding, the provisions of § 2.2-4030 of the Code of Virginia shall apply.

Deemed approvals shall be construed as the commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) 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 a deemed-to-be-approved 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 of the Code of Virginia, the court may require the appellant to file a bond pursuant to § 8.01-676.1 of the Code of Virginia, 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.

The applicants, and only the applicants, shall have the authority to extend any of the time periods for review of the application, which are specified in 12VAC5-220-230. 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.

For purposes of project review, any scheduled deadlines that fall on a weekend or state holiday shall be advanced to the next work day.

D. Regional health planning agency required notifications. Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify the local governing bodies in the planning district, health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in this chapter, in the county or city wherein a project is proposed or a contiguous county or city and (ii) the date, time and place the final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record of the public hearing that includes any comments of the local governing bodies of the health planning district and all other public comments. A copy of the verbatim record shall be provided to the department. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

E. Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and 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, unless written notification has been provided. See definition of "ex parte."

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.7, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997; Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 20, Issue 26, eff. September 27, 2004.

12VAC5-220-240. Participation by other persons.

Any person affected by a proposed project under review may directly submit written opinions, data and other information to the appropriate regional health planning agency and the commissioner for consideration prior to their final action.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.8, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-250. Amendment to an application.

The applicant shall have the right to amend an application at any time. Any amendment which is made to an application following the public hearing and prior to the issuance of a certificate unless otherwise specified in this chapter shall constitute a new application and shall be subject to the review requirements set forth in Part V of this chapter. If such amendment is made subsequent to the issuance of a certificate of public need, it shall be reviewed in accordance with 12VAC5-220-130.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.9, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-260. Withdrawal of an application.

The applicant shall have the right to withdraw an application from consideration at any time, without prejudice by written notification to the commissioner.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.10, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-270. Action on an application.

A. Commissioner's responsibility. Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. 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 either 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.

Conditions of approval. The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of care at a reduced rate to indigents, or (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) 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. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreement shall be subject to a civil penalty of $100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

B. Notification process-extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency within the time frames specified in 12VAC5-220-230 B unless authorization is given by the applicant or applicants to extend the time period. Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of this chapter, between the commissioner and the applicant.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 5.11, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 13, Issue 7, eff. January 24, 1997; Volume 19, Issue 8, eff. February 3, 2003.

Part VI. Expedited Review Process

12VAC5-220-280. Applicability.

Capital expenditures as contained in subdivision 8 of "project" as defined in § 32.1-102.1 of the Code of Virginia or projects that involve relocation at the same site of 10 beds or 10% of the beds, whichever is less, from one existing physical facility to another, when the cost of such relocation is less than $5 million, shall be subject to an expedited review process.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 6.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-290. Application forms.

A. Obtaining application forms. Application forms for an expedited review shall be available from the department upon the request of the applicant. The department shall transmit application forms to the applicant within seven days of receipt of such request.

B. Application fees. The department shall collect application fees for applications that request a certificate of public need under the expedited review process. No application will be reviewed until the required application fee is paid as provided in 12VAC5-220-180 B.

C. Filing application forms. All requests for a certificate of public need in accordance with the expedited review process shall be reviewed by the department and the regional health planning agency which shall each forward a recommendation to the commissioner within 40 days from the date the submitted application has been deemed complete. No application for expedited review shall be reviewed until the application form has been received by the department and the appropriate regional health planning agency, has been deemed complete, and the application fee has been paid to the department.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 6.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; amended, Virginia Register Volume 14, Issue 12, eff. April 2, 1998.

12VAC5-220-300. Participation by other persons.

Any person directly affected by the review of a project under the expedited review process may submit written opinions, data and other information to the appropriate regional health planning agency and to the commissioner prior to their final action.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 6.3, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

12VAC5-220-310. Action on application.

A. Decisions to approve any project under the expedited review process shall be rendered by the commissioner within 45 days of the receipt of such completed request. The commissioner shall approve and issue a certificate for any project which is determined to meet the criteria for expedited review set forth in 12VAC5-220-280.

B. If the commissioner determines that a project does not meet the criteria for an expedited review set forth in 12VAC5-220-280, the applicant will be notified in writing of such determination within 45 days of the receipt of such request. In such cases, the department will forward the appropriate forms to the project applicant for use in filing an application for review of a project in the appropriate review cycle in accordance with Part V of this chapter.

C. Any project which does not qualify for an expedited review in accordance with 12VAC5-220-280, as determined by the commissioner, shall be exempted from the requirements of 12VAC5-220-180 A and B when such project is filed for consideration in accordance with Part V of this chapter.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 6.4, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994.

Part VII. New Nursing Home Bed Review Process

12VAC5-220-325. Applicability.

The following categories of projects as determined by the State Health Commissioner shall be subject to the nursing home bed review process when they involve an increase in the number of nursing home facility beds in Virginia. (For Continuing Care Retirement Community nursing home beds, see Part V (12VAC5-220-170 et seq.) of this chapter.)

1. The establishment of a nursing home, intermediate care facility, or extended care facility, except when such nursing home, intermediate care facility, or extended care facility is

proposed by a continuing care retirement community and the project is sponsored by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

2. An increase in the total number of beds in an existing or authorized nursing home, intermediate care facility, or extended care facility, except when the nursing home, intermediate care facility, or extended care facility is a component of a continuing care retirement community and the project is sponsored by a continuing care provider registered with the State Corporation Commission pursuant to Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

3. An increase in the total number of nursing home beds, intermediate care facility beds, or extended care facility beds in an existing or authorized medical care facility which is not a dedicated nursing home, intermediate care facility, or extended care facility.

4. The introduction into any 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 except when such medical care facility is an existing nursing home as defined in § 32.1-123 of the Code of Virginia.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-335. Request for Applications (RFA).

Pursuant to § 32.1-102.3:2 A, B, and C of the Code of Virginia, the commissioner shall periodically issue a Request for Applications (RFA). An RFA shall be issued at least annually.

A RFA from project applicants proposing projects which would result in an increase in the number of beds are provided shall be based on analyses of the need for increases in the bed supply in each of Virginia's planning districts in accordance with the applicable standards included in the State Medical Facilities Plan. Such RFAs shall also include a schedule for the review of applications submitted in response to the RFA which allows for at least 120 days between the day on which the RFA is issued and the first day of the review cycle for such applications.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-345. Limitation on acceptance of RFA applications.

Applications for projects listed in § 32.1-102.3:2 A, B, and C of the Code of Virginia shall only be accepted for review when properly filed in response to a RFA. Furthermore, the commissioner shall only accept for review applications which propose projects located in the planning districts from which applications are requested in the RFA and propose authorization of a number of new beds are provided which is less than or equal to the total number of beds identified as needed for the planning district in which the project will be located.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-355. RFA project application forms.

A. Letter of intent. A RFA project applicant shall file a letter of intent with the commissioner to request appropriate application forms, and submit a copy of that letter to the appropriate regional health planning agency by the letter of intent deadline specified in the RFA. The letter shall identify the owner, the type of project for which an application is requested, and the proposed scope (size) and location of the proposed project. The department shall transmit application forms to the applicant within seven days of the receipt of the letter of intent. A letter of intent filed with the department shall be considered void if an application is not filed for the project by the application deadline specified in the RFA.

B. Application fees. The department shall collect application fees for RFA applications that request a certificate of public need. The fee required for an application is 1.0% of the proposed capital expenditure for the project but no less than $1,000 and no more than $20,000. No application will be deemed to be complete for review until the required application fee is paid.

C. Filing application forms. Applications must be submitted to the department and the appropriate regional health planning agency by the application filing deadline specified in the RFA. In order to verify the department and the appropriate regional health planning agency's receipt of the application, the applicant shall transmit the document electronically, or prepare in triplicate two copies to be submitted to the department and one copy to be submitted to the appropriate regional health planning agency and sent by certified mail or a delivery service, return receipt requested, or by hand, with a signed receipt to be provided. No application shall be deemed to have been submitted until required copies have been received by the department and the appropriate regional health planning agency.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003; Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-365. Review for completeness.

The applicant shall be notified by the department within 15 days following receipt of the application if additional information is required to complete the application or the application is complete as submitted. No application shall be reviewed until the department has determined that it is complete. To be complete, all questions and information items requested on the application must be completely addressed and the application fee submitted. Additional information required to complete an application shall be submitted to the department and the appropriate regional health planning agency at least five days prior to the first day of the review cycle, as specified in the RFA, to be considered in the review cycle.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-375. Consideration of RFA applications.

RFA applications proposed for the same planning district shall be considered as competing applications by the commissioner. The commissioner shall determine whether an application is competing and provide written notification to the competing applicants and the regional health planning agency.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 26, Issue 2, eff. November 1, 2009.

12VAC5-220-385. Review of complete application.

A. Review cycle. The department shall provide written notification to applicants specifying the acceptance date and review schedule of completed applications, including the date for any informal fact-finding conference that may be held between the eightieth and ninetieth day of the review cycle. The regional health planning agency shall conduct no more than two meetings, one of which must be a public hearing conducted by the regional health planning agency board or a subcommittee of the board and provide applicants with an opportunity, prior to the vote, to respond to any comments made about the project by the regional health planning agency staff, any information in a staff report, the comments of the local governing bodies in the health planning district, all other public comments, or comments by those voting in completing its review and recommendation by the sixtieth day of the cycle. By the seventieth day of the review cycle, the department shall complete its review and recommendation of an application and transmit the same to the applicant or applicants and other appropriate persons. By the seventy-fifth day of the review cycle, the department shall transmit to the applicants and other

appropriate persons, its determination whether an informal fact-finding conference is necessary.

An informal fact-finding conference shall be held when (i) determined necessary by the department or (ii) requested by any person seeking to demonstrate good cause. Any person seeking to demonstrate good cause shall file, no later than four days after the department has completed its review and recommendation of an application and has transmitted the same to the applicants and to persons who have prior to the issuance of the report requested a copy in writing, written notification with the commissioner, applicant or applicants and other competing applicants, and regional health planning agency stating the grounds for good cause and providing the factual basis therefor under oath.

For purposes of this section, "good cause" means 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 regional health planning agency. (See § 32.1-102.6 of the Code of Virginia.)

B. Time period for review. The review period shall begin on the first day of the applicable review cycle within which an application is determined to be complete, in accordance with scheduled batch review cycles described in 12VAC5-220-200. If the application is not determined to be complete for the applicable batch cycle within 40 calendar days from the date of submission, the application may be refiled in the next applicable batch cycle.

If the regional health planning agency has not completed its review by the sixtieth day of the review cycle, or such other period in accordance with the applicant's request for extension, and submitted its recommendation within ten calendar days after the completion of its review, the department shall, on the eleventh day after expiration of the regional health planning agency's review period, proceed as if the regional health planning agency has recommended approval of the proposed project.

In any case in which an informal fact-finding conference is not held, the project 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 that an informal fact-finding conference is not necessary. See 12VAC5 220-230 A.

In any case in which an informal fact-finding conference is held, a date shall be established for closing of the record which shall not be more than 30 calendar days after the date for holding the informal fact-finding conference.

C. Determination by the commissioner. If a determination whether a public need exists for a project is not made by the commissioner within 45 calendar days of the closing of the record, the commissioner shall notify the applicant or applicants and any person seeking to show good cause, in writing, that the application or the applications of each shall be deemed approved 25 calendar days after the expiration of such 45-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 25-calendar-day period. The validity or timeliness of the aforementioned notice shall not, in any event, prevent, delay or otherwise

impact the effectiveness of this section.

In any case when a determination whether a public need exists for a project is not made by the commissioner within 70 calendar days after closing of the record, the application shall be deemed approved and a certificate shall be granted.

If a determination whether a public need for a project exists is not made by the commissioner within 45 calendar days of the closing of the record, any applicant who is competing in the relevant batch review cycle or who has filed an application in response to the relevant Request for Applications issued pursuant to 12VAC5-220-355 may, prior to the application being deemed approved petition for immediate injunctive relief pursuant to § 2.2-4030 of the Code of Virginia, naming as respondents the commissioner and all parties to the case. During the pendency of proceeding, no applications shall be deemed to be approved. In such a proceeding, the provisions of § 2.2-4030 of the Code of Virginia shall apply.

Deemed approvals shall be construed as the commissioner's case decision on the application pursuant to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia) 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 petition prior to the date on which the application was approved, shall be deemed to be a person showing good cause for purposes of appeal of a deemed-to-be-approved 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 of the Code of Virginia, the court may require the appellant to file a bond pursuant to § 8.01-676.1 of the Code of Virginia, 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.

The applicants, and only the applicants, shall have the authority to extend any of the time periods for review of the application, which are specified in 12VAC5-220-230. 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.

D. Regional health planning agency required notifications. Upon notification of the acceptance date of a complete application as set forth in subsection A of this section, the regional health planning agency shall provide written notification of its review schedule to the applicant. The regional health planning agency shall notify the local governing bodies in the planning district, health care providers and specifically identifiable consumer groups who may be affected by the proposed project directly by mail and shall also give notice of the public hearing in a newspaper of general circulation in such county or city wherein a project is proposed or a contiguous county or city at least nine days prior to such public hearing. Such notification by the regional health planning agency shall include: (i) the date and location of the public hearing which shall be conducted on the application except as otherwise provided in this chapter, in the county or city wherein a project is proposed or a contiguous county or city; and (ii) the date, time and place the

final recommendation of the regional health planning agency shall be made. The regional health planning agency shall maintain a verbatim record of the public hearing that includes any comments of the local governing bodies of the health planning district and all other public comments. A copy of the verbatim record shall be provided to the department. Such public hearing record shall be maintained for at least a one-year time period following the final decision on a certificate of public need application. See definition of "public hearing."

E. Ex parte contact. After commencement of a public hearing and before a final decision is made, there shall be no ex parte contacts between the State Health Commissioner and 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, unless written notification has been provided. See definition of "ex parte."

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 14, Issue 12, eff. April 2, 1998; Volume 19, Issue 8, eff. February 3, 2003; Volume 20, Issue 26, eff. September 27, 2004.

12VAC5-220-395. Participation by other persons.

Any person affected by a proposed project under review may directly submit written opinions, data and other information to the appropriate regional health planning agency and the commissioner for consideration prior to their final action.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-405. Amendment to an application.

The applicant shall have the right to amend an application at any time. Any amendment which is made to an application following the public hearing and prior to the issuance of a certificate unless otherwise specified in this chapter shall constitute a new application and shall be subject to the review requirements set forth in this part of this chapter. If such amendment is made subsequent to the issuance of a certificate of public need, it shall be reviewed in accordance with 12VAC5-220-130.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-410. Withdrawal of an application.

The applicant shall have the right to withdraw an application from consideration at any time without prejudice by written notification to the commissioner.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-420. Action on an application.

A. Commission's responsibility. Decisions as to approval or disapproval of applications or a portion thereof for certificates of public need shall be rendered by the commissioner. 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.

The commissioner may condition the approval of an application for a project (i) on the agreement by the applicant to provide an acceptable level of care at a reduced rate to indigents or, (ii) on the agreement of the applicant to provide care to persons with special needs, or (iii) 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. The terms of such agreements shall be specified in writing prior to the commissioner's decision to approve a project. Any person willfully refusing, failing or neglecting to honor such agreements shall be subject to a civil penalty of $100 per violation per day from the date of receipt from the department of written notice of noncompliance until the date of compliance. Upon information and belief that a person has failed to honor such agreement in accordance with this provision, the department shall notify the person in writing and 15 days shall be provided for a response in writing including a plan for immediate correction. In the absence of an adequate response or necessary compliance or both, a judicial action shall be initiated in accordance with the provisions of § 32.1-27 of the Code of Virginia.

B. Notification process – extension of review time. The commissioner shall make a final determination on an application for a certificate of public need and provide written notification detailing the reasons for such determination to the applicant with a copy to the regional health planning agency within the time frames specified in 12VAC5-220-385 B unless an authorization is given by the applicants to extend the time period. Such written notification shall also reference the factors and bases considered in making a decision on the application and, if applicable, the remedies available for appeal of such decision and the progress reporting requirements. The

commissioner may approve a portion of a project provided the portion to be approved is agreed to by the applicant following consultation, which may be subject to the ex parte provision of this chapter, between the commissioner and the applicant.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003.

Part VIII. Duration, Extension, and Revocation of Certificates

12VAC5-220-430. Duration.

A certificate of public need shall be valid for a period of 12 months and shall not be transferrable from the certificate holder to any other legal entity regardless of the relationship, under any circumstances.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 7.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-440. Extension.

A certificate of public need is valid for a 12-month period and may be extended by the commissioner for additional time periods which shall be specified at the time of the extension.

A. Basis for certificate extension within 24 months. An extension of a certificate of public need beyond the expiration date may be granted by the commissioner by submission of evidence to demonstrate that progress is being made towards the completion of the authorized project as defined in 12VAC5-220-450. Such request shall be submitted to the commissioner in writing with a copy to the appropriate regional health planning agency at least 30 days prior to the expiration date of the certificate or period of extension.

B. Basis for certificate extension beyond 24 months. An extension of a certificate of public need beyond the two years following the date of issuance may be granted by the commissioner when substantial and continuing progress is being made towards the development of the authorized project. In making the determination, the commissioner shall consider whether: (i) any delays in development of the project have been caused by events beyond the control of the owner; (ii) substantial delays in development of the project may not be attributed to the owner; and (iii) a schedule of completion has been provided and determined to be reasonable. Such request shall be submitted in writing with a copy to the appropriate regional health planning agency at least

30 days prior to the expiration date of the certificate of period of extension. The commissioner shall not grant an extension to the schedule for completion of a project beyond three years (36 months) of the date of certificate issuance or beyond the time period approved at the date of certificate issuance, whichever is greater, unless such extension is authorized in accordance with the provisions for a significant change. See 12VAC5-220-130, Significant change limitation.

C. Basis for indefinite extension. A certificate shall be considered for an indefinite extension by the commissioner when satisfactory completion of a project has been demonstrated as set forth in subsection C of 12VAC5-220-450.

D. Regional health planning agency review. All requests for an extension of a certificate of public need shall be reviewed by the appropriate regional health planning agency within 30 days of receipt by the department and the regional health planning agency. The recommendations on the request by that agency shall be forwarded to the commissioner who shall act upon the progress report within 35 days of receipt by the department and the regional health planning agency. Failure of the regional health planning agency to notify the commissioner within the time frame prescribed shall constitute a recommendation of approval by such regional health planning agency.

E. Notification of decision. Extension of a certificate of public need by the commissioner shall be made in the form of a letter from the commissioner with a copy to the appropriate regional health planning agency and shall become part of the official project file.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 7.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-450. Demonstration of progress.

The applicant shall provide reports to demonstrate progress made towards the implementation of an authorized project in accordance with the schedule of development which shall be included in the application. Such progress reports shall be filed in accordance with the following intervals and contain such evidence as prescribed at each interval:

A. Twelve months following issuance. Documentation that shows: (i) proof of ownership or control of site; (ii) the site meets all zoning and land use requirements; (iii) architectural planning has been initiated; (iv) preliminary architectural drawings and working drawings have been submitted to appropriate state reviewing agencies and the State Fire Marshal; (v) construction financing has been completed or will be completed within two months and (vi) purchase orders or lease agreements exist for equipment and new service projects.

B. Twenty-four months following issuance. Documentation that shows that (i) all required financing is completed; (ii) preconstruction site work has been initiated; (iii) construction bids

have been advertised and the construction contractor has been selected; (iv) the construction contract has been awarded and (v) construction has been initiated.

C. Upon completion of a project. Any documentation not previously provided which: (i) shows the final costs of the project, including the method(s) of financing; and (ii) shows that the project has been completed as proposed in accordance with the application originally submitted, including any subsequent approved changes. See "completion" as defined in 12VAC5-220-10.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 7.3, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-460. Revocation of certificate.

A. Lack of progress. Failure of any project to meet the progress requirements stated in 12VAC5-220-450 shall be cause for certificate revocation, unless the commissioner determines sufficient justification exists to permit variance, considering factors enumerated in 12VAC5-220-450.

B. Failure to report progress. Failure of an applicant to file progress reports on an approved project in accordance with 12VAC5-220-450 shall be cause for revocation, unless, due to extenuating circumstances, the commissioner, in his sole discretion, extends the certificate, in accordance with subsection B of 12VAC5-220-440.

C. Unapproved changes. Exceeding a capital expenditure amount not authorized by the commissioner or not consistent with the schedule of completion shall be cause for revocation. See definition of "significant change" and "schedule of completion."

D. Failure to initiate construction. Failure to initiate construction of the project within two years following the date of issuance of the certificate of public need shall be cause for revocation, unless due to extenuating circumstances the commissioner extends the certificate, in accordance with subsection B of 12VAC5-220-440.

E. Misrepresentation. Upon determination that an applicant has knowingly misrepresented or knowingly withheld relevant data or information prior to issuance of a certificate of public need, the commissioner may revoke said certificate.

F. Noncompliance with assurances. Failure to comply with the assurances or intentions set forth in the application or written assurances provided at the time of issuance of a certificate of public need shall be cause for revocation.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 7.4, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

Part IX. Appeals

12VAC5-220-470. Judicial review.

Appeals to a circuit court shall be governed by the Virginia Administrative Process Act, § 2.2-4000 et seq. of the Code of Virginia, and Part Two A of the Rules of the Supreme Court of Virginia.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 8.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003.

Part X. Sanctions

12VAC5-220-480. Violation of rules and regulations.

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

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 9.1, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

12VAC5-220-490. Injunctive relief.

On petition of the commissioner, the Board of Health 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.

Statutory Authority

§§ 32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-000 § 9.2, eff. June 30, 1993; amended, Virginia Register Volume 10, Issue 17, eff. June 15, 1994; recodified, Virginia Register Volume 13, Issue 7, eff. January 24, 1997.

FORMS (12VAC5-220).

Application for Expedited Review for Certificate of Public Need (eff. 6/94).

Registration Form for Capital Expenditures of $1,000,000 or More But Less than $2,000,000 Which are Not Defined as a Project on or After July 1, 1993.

Request for Extension of a Certificate of Public Need Beyond Two Years from Date of Issuance.

Request for Extension of a Certificate of Public Need Beyond One Year, But Less then Two Years from Date of Issuance (Rev. 7/26/93).

Application for a Medical Care Facilities Certificate of Public Need - Outpatient Facilities (Rev. 12/10/92).

Application for a Medical Care Facilities Certificate of Public Need - Hospitals (Rev. 12/10/92).

Application for a Medical Care Facilities Certificate of Public Need - Long-Term Care Facilities (Rev. 10/2007).

Statutory Authority

Historical Notes

Virginia Administrative Code
Title 12. Health
Agency 5. Department of Health
Chapter 230. State Medical Facilities Plan

Part I. Definitions and General Information

12VAC5-230-10. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Acute psychiatric services" means hospital-based inpatient psychiatric services provided in distinct inpatient units in general hospitals or freestanding psychiatric hospitals.

"Acute substance abuse disorder treatment services" means short-term hospital-based inpatient treatment services with access to the resources of (i) a general hospital, (ii) a psychiatric unit in a general hospital, (iii) an acute care addiction treatment unit in a general hospital licensed by the Department of Health, or (iv) a chemical dependency specialty hospital with acute care medical and nursing staff and life support equipment licensed by the Department of Behavioral Health and Developmental Services.

"Bassinet" means an infant care station, including warming stations and isolettes.

"Bed" means that unit, within the complement of a medical care facility, subject to COPN review as required by Article 1.1 (§ 32.1-102.1 et seq.) of the Code of Virginia and designated for use by patients of the facility or service. For the purposes of this chapter, bed does include cribs and bassinets used for pediatric patients but does not include cribs and bassinets in the newborn nursery or neonatal special care setting.

"Cardiac catheterization" means an invasive procedure where a flexible tube is inserted into the patient through an extremity blood vessel and advanced under fluoroscopic guidance into the heart chambers or coronary arteries. A cardiac catheterization may be conducted for diagnostic or therapeutic purposes but does not include a simple right heart catheterization for monitoring purposes as might be performed in an electrophysiology laboratory, pulmonary angiography as an isolated procedure, or cardiac pacing through a right electrode catheter.

"Commissioner" means the State Health Commissioner.

"Competing applications" means applications for the same or similar services and facilities that are proposed for the same health planning district, or same health planning region for projects reviewed on a regional basis, and are in the same batch review cycle.

"Complex therapeutic cardiac catheterization" means the performance of cardiac catheterization for the purpose of correcting or improving certain conditions that have been determined to exist in the heart or great arteries or veins of the heart, specifically catheter-based procedures for structural treatment to correct congenital or acquired structural or valvular abnormalities.

"Computed tomography" or "CT" means a noninvasive diagnostic technology that uses computer analysis of a series of cross-sectional scans made along a single axis of a bodily structure or tissue to construct an image of that structure.

"Continuing care retirement community" or "CCRC" means a retirement community consistent with the requirements of Chapter 49 (§ 38.2-4900 et seq.) of Title 38.2 of the Code of Virginia.

"COPN" means a Medical Care Facilities Certificate of Public Need for a project as required in Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.

"COPN program" means the Medical Care Facilities Certificate of Public Need Program implementing Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.

"DEP" means diagnostic equivalent procedure, a method for weighing the relative value of various cardiac catheterization procedures as follows: a diagnostic cardiac catheterization equals 1 DEP, a simple therapeutic cardiac catheterization equals 2 DEPs, a same session procedure (diagnostic and simple therapeutic) equals 3 DEPs, and a complex therapeutic cardiac catheterization equals 5 DEPs. A multiplier of 2 will be applied for a pediatric procedure (i.e., a pediatric diagnostic cardiac catheterization equals 2 DEPs, a pediatric simple therapeutic cardiac catheterization equals 4 DEPs, and a pediatric complex therapeutic cardiac catheterization equals 10 DEPs.)

"Diagnostic cardiac catheterization" means the performance of cardiac catheterization for the purpose of detecting and identifying defects in the great arteries or veins of the heart or abnormalities in the heart structure, whether congenital or acquired.

"Direction" means guidance, supervision, or management of a function or activity.

"Gamma knife®" means the name of a specific instrument used in stereotactic radiosurgery.

"Health planning district" means the same contiguous areas designated as planning districts by the Virginia Department of Housing and Community Development or its successor.

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

"Health system" means an organization of two or more medical care facilities, including hospitals, that are under common ownership or control and are located within the same health planning district, or health planning region for projects reviewed on a regional basis.

"Hospital" means a medical care facility licensed as an inpatient hospital or outpatient surgical center by the Department of Health or as a psychiatric hospital by the Department of Behavioral Health, and Developmental Services.

"ICF/MR" means an intermediate care facility for the mentally retarded.

"Indigent" means any person whose gross family income is equal to or less than 200% of the federal Nonfarm Poverty Level or income levels A through E of 12VAC5-200-10 and who is

uninsured.

"Inpatient" means a patient who is hospitalized longer than 24 hours for health or health related services.

"Intensive care beds" or "ICU" means inpatient beds located in the following units or categories:

1. General intensive care units are those units where patients are concentrated by reason of serious illness or injury regardless of diagnosis. Special lifesaving techniques and equipment are immediately available and patients are under continuous observation by nursing staff;

2. Cardiac care units, also known as Coronary Care Units or CCUs, are units staffed and equipped solely for the intensive care of cardiac patients; and

3. Specialized intensive care units are any units with specialized staff and equipment for the purpose of providing care to seriously ill or injured patients based on age selected categories of diagnoses, including units established for burn care, trauma care, neurological care, pediatric care, and cardiac surgery recovery but does not include bassinets in neonatal special care units.

"Lithotripsy" means a noninvasive therapeutic procedure to (i) crush renal and biliary stones using shock waves (i.e., renal lithotripsy) or (ii) treat certain musculoskeletal conditions and relieve the pain associated with tendonitis (i.e., orthopedic lithotripsy).

"Long-term acute care hospital" or "LTACH" means an inpatient hospital that provides care for patients who require a length of stay greater than 25 days and is, or proposes to be, certified by the Centers for Medicare and Medicaid Services as a long-term care inpatient hospital pursuant to 42 CFR Part 412. An LTACH may be either a freestanding facility or located within an existing or host hospital.

"Magnetic resonance imaging" or "MRI" means a noninvasive diagnostic technology using a nuclear spectrometer to produce electronic images of specific atoms and molecular structures in solids, especially human cells, tissues and organs.

"Medical rehabilitation" means those services provided consistent with 42 CFR 412.23 nd 412.24.

"Medical/surgical" means those services available for the care and treatment of patients not requiring specialized services.

"Minimum survival rates" means the base percentage of transplant recipients who survive at least one year or for such other period of time as specified by the United Network for Organ Sharing (UNOS).

"Neonatal special care" means care for infants in one or more of the higher service levels designated in 12VAC5-410-443 .

"Nursing facility" means those facilities or components thereof licensed to provide long-term nursing care.

"Obstetrical services" means the distinct organized program, equipment and care related to pregnancy and the delivery of newborns in inpatient facilities.

"Off-site replacement" means the relocation of existing beds or services from an existing medical care facility site to another location within the same health planning district.

"Open heart surgery" means a surgical procedure requiring the use or immediate availability of a heart-lung bypass machine or "pump." The use of the pump during the procedure distinguishes "open heart" from "closed heart" surgery.

"Operating room" means a room used solely or principally for the provision of surgical procedures involving the administration of anesthesia, multiple personnel, recovery room access, and a fully controlled environment.

"Operating room use" means the amount of time a patient occupies an operating room and includes room preparation and cleanup time.

"Operating room visit" means one session in one operating room in an inpatient hospital or outpatient surgical center, which may involve several procedures. Operating room visit may be used interchangeably with "operation" or "case."

"Outpatient" means a patient who visits a hospital, clinic, or associated medical care facility for diagnosis or treatment, but is not hospitalized 24 hours or longer.

"Pediatric" means patients younger than 18 years of age. Newborns in nurseries are excluded from this definition.

"Perinatal services" means those resources and capabilities that all hospitals offering general level newborn services as described in 12VAC5-410-443 must provide routinely to newborns.

"PET/CT scanner" means a single machine capable of producing a PET image with a concurrently produced CT image overlay to provide anatomic definition to the PET image. For the purpose of granting a COPN, the State Board of Health pursuant to § 32.1-102.2 A 6 of the Code of Virginia has designated PET/CT as a specialty clinical service. A PET/CT scanner shall be reviewed under the PET criteria as an enhanced PET scanner unless the CT unit will be used independently. In such cases, a PET/CT scanner that will be used to take independent PET and CT images will be reviewed under the applicable PET and CT services criteria.

"Planning horizon year" means the particular year for which bed or service needs are projected.

"Population" means the census figures shown in the most current series of projections published by a demographic entity as determined by the commissioner.

"Positron emission tomography" or "PET" means a noninvasive diagnostic or imaging modality using the computer-generated image of local metabolic and physiological functions in tissues produced through the detection of gamma rays emitted when introduced radionuclides decay and release positrons. A PET device or scanner may include an integrated CT to provide anatomic structure definition.

"Primary service area" means the geographic territory from which 75% of the patients of an existing medical care facility originate with respect to a particular service being sought in an application.

"Procedure" means a study or treatment or a combination of studies and treatments identified by a distinct ICD-10 or CPT code performed in a single session on a single patient.

"Qualified" means meeting current legal requirements of licensure, registration, or certification in Virginia or having appropriate training, including competency testing, and experience commensurate with assigned responsibilities.

"Radiation therapy" means treatment using ionizing radiation to destroy diseased cells and for the relief of symptoms. Radiation therapy may be used alone or in combination with surgery or chemotherapy.

"Relevant reporting period" means the most recent 12-month period, prior to the beginning of the applicable batch review cycle, for which data is available from VHI or a demographic entity as determined by the commissioner.

"Rural" means territory, population, and housing units that are classified as "rural" by the Bureau of the Census of the U.S. Department of Commerce, Economic and Statistics Administration.

"Simple therapeutic cardiac catheterization" means the performance of cardiac catheterization for the purpose of correcting or improving certain conditions that have been determined to exist in the heart, specifically catheter-based treatment procedures for relieving coronary artery narrowing.

"SMFP" means the state medical facilities plan as contained in Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia used to make medical care facilities and services needs decisions.

"Stereotactic radiosurgery" or "SRS" means the use of external radiation in conjunction with a stereotactic guidance device to very precisely deliver a therapeutic dose to a tissue volume. SRS may be delivered in a single session or in a fractionated course of treatment up to five sessions.

"Stereotactic radiotherapy" or "SRT" means more than one session of stereotactic radiosurgery.

"Substance abuse disorder treatment services" means services provided to individuals for the prevention, diagnosis, treatment, or palliation of chemical dependency, which may include attendant medical and psychiatric complications of chemical dependency. Substance abuse disorder treatment services are licensed by the Department of Behavioral Health, and Developmental Services.

"Supervision" means to direct and watch over the work and performance of others.

"Use rate" means the rate at which an age cohort or the population uses medical facilities and services. The rates are determined from periodic patient origin surveys conducted for the department by the regional health planning agencies or other health statistical reports authorized by Chapter 7.2 (§ 32.1-276.2 et seq.) of Title 32.1 of the Code of Virginia.

"VHI" means the health data organization defined in § 32.1-276.4 of the Code of Virginia and under contract with the Virginia Department of Health.

Statutory Authority

§§32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-100 § 1, eff. July 1, 1993; amended, Virginia Register Volume 19, Issue 8, eff. February 3, 2003; Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009; amended, Virginia Register Volume 37, Issue 14, eff. March 31, 2021.

12VAC5-230-30. Guiding principles in the development of project review criteria and standards.

The following general principles serve as the basis for the development of the review criteria and standards for specific medical care facilities and services contained in this document:

1. The COPN program is based on the understanding that excess capacity or underutilization of medical facilities are detrimental to both cost effectiveness and quality of medical services in Virginia.

2. The COPN program seeks the geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies.

3. The COPN program seeks to promote the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay.

4. The COPN program seeks to encourage the conversion of facilities to new and efficient uses and the reallocation of resources to meet evolving community needs.

5. The COPN program discourages the proliferation of services that would undermine the ability of essential community providers to maintain their financial viability.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from VR355-30-100 § 3, eff. July 1, 1993; amended, Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-40. General application filing criteria.

A. In addition to meeting the applicable requirements of this chapter, applicants for a Certificate of Public Need shall include documentation in their application that their project addresses the applicable requirements listed in § 32.1-102.3 of the Code of Virginia.

B. The burden of proof shall be on the applicant to produce information and evidence that the project is consistent with the applicable requirements and review policies as required under Article 1.1 (§ 32.1-102.1 et seq.) of Chapter 4 of Title 32.1 of the Code of Virginia.

C. The commissioner may condition the approval of a COPN by requiring an applicant to: (i) provide a level of care at a reduced rate to indigents, (ii) accept patients requiring specialized care, or (iii) facilitate the development and operation of primary medical care services in

designated medically underserved areas of the applicant's service area. The applicant must actively seek to comply with the conditions place on any granted COPN.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-50. Project costs.

The capital development costs of a facility and the operating expenses of providing the authorized services should be comparable to the costs and expenses of similar facilities with the health planning region.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-60. When competing applications received.

In reviewing competing applications, preference may be given to an applicant who:

1. Has an established performance record in completing projects on time and within the authorized operating expenses and capital costs;

2. Has both lower capital costs and operating expenses than his competitors and can demonstrate that his estimates are credible;

3. Can demonstrate a consistent compliance with state licensure and federal certification regulations and a consistent history of few documented complaints, where applicable; or

4. Can demonstrate a commitment to serving his community or service area as evidenced by unreimbursed services to the indigent and providing needed but unprofitable services, taking into account the demands of the particular service area.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-70. Calculation of utilization of services provided with mobile equipment.

A. The minimum service volume of a mobile unit shall be prorated on a site-by-site basis reflecting the amount of time that proposed mobile units will be used, and existing mobile units have been used, during the relevant reporting period, at each site using the following formula:

Required full-time minimum service volume	X	Number of days the service will be on site each week	X 0.2 =	Prorated minimum services volume (not to exceed the required full-time minimum service volume)

B. The average annual utilization of existing and approved CT, MRI, PET, lithotripsy, and catheterization services in a health planning district shall be calculated for such services as follows:

$$\left(\frac{\text{Total volume of all units of the relevant service in the reporting period}}{\left(\text{\# of existing or approved fixed units} \times \text{Fixed unit minimum service volume} \right) + Y \text{ Utilization}} \right) \times 100 = \%\ \text{Average Utilization}$$

Y = the sum of the minimum service volume of each mobile site in the health planning district with the minimum services volume for each such site prorated according to subsection A of this section.

C. This section does not prohibit an applicant from seeking to obtain a COPN for a fixed site service provided capacity for the services has been achieved as described in the applicable service section.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-80. When institutional expansion needed.

A. Notwithstanding any other provisions of this chapter, the commissioner may grant approval for the expansion of services at an existing medical care facility in a health planning district with an excess supply of such services when the proposed expansion can be justified on the basis of a facility's need having exceeded its current service capacity to provide such service or on the geographic remoteness of the facility.

B. If a facility with an institutional need to expand is part of a health system, the underutilized services at other facilities within the health system should be reallocated, when appropriate, to the facility with the institutional need to expand before additional services are approved for the

applicant. However, underutilized services located at a health system's geographically remote facility may be disregarded when determining institutional need for the proposed project.

C. This section is not applicable to nursing facilities pursuant to § 32.1-102.3:2 of the Code of Virginia.

D. Applicants shall not use this section to justify a need to establish new services.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-90. Travel time.

CT services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-100. Need for new fixed site or mobile service.

A. No new fixed site or mobile CT service should be approved unless fixed site CT services in the health planning district performed an average of 7,400 procedures per existing and approved CT scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing providers in the health planning district. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of CT scanners in such health planning district.

B. Existing CT scanners used solely for simulation with radiation therapy treatment shall be exempt from the utilization criteria of this article when applying for a COPN. In addition, existing CT scanners used solely for simulation with radiation therapy treatment may be disregarded in computing the average utilization of CT scanners in such health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-110. Expansion of fixed site service.

Proposals to expand an existing medical care facility's CT service through the addition of a CT scanner should be approved when the existing services performed an average of 7,400 procedures per scanner for the relevant reporting period. The commissioner may authorize placement of a new unit at the applicant's existing medical care facility or at a separate location within the applicant's primary service area for CT services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-120. Adding or expanding mobile CT services.

A. Proposals for mobile CT scanners shall demonstrate that, for the relevant reporting period, at least 4,800 procedures were performed and that the proposed mobile unit will not significantly reduce the utilization of existing CT providers in the health planning district.

B. Proposals to convert authorized mobile CT scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, at least 6,000 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing CT providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-130. Staffing.

CT services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 2. Criteria and Standards for Magnetic Resonance Imaging

12VAC5-230-140. Travel time.

MRI services should be within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-150. Need for new fixed site service.

No new fixed site MRI services should be approved unless fixed site MRI services in the health planning district performed an average of 5,000 procedures per existing and approved fixed site MRI scanner during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing fixed site MRI providers in the health planning district. The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of MRI scanners in such health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-160. Expansion of fixed site service.

Proposals to expand an existing medical care facility's MRI services through the addition of an MRI scanner may be approved when the existing service performed an average of 5,000 MRI procedures per scanner during the relevant reporting period. The commissioner may authorize placement of the new unit at the applicant's existing medical care facility, or at a separate location within the applicant's primary service area for MRI services, provided the proposed expansion is not likely to significantly reduce the utilization of existing providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-170. Adding or expanding mobile MRI services.

A. Proposals for mobile MRI scanners shall demonstrate that, for the relevant reporting period, at least 2,400 procedures were performed and that the proposed mobile unit will not significantly

reduce the utilization of existing MRI providers in the health planning district.

B. Proposals to convert authorized mobile MRI scanners to fixed site scanners shall demonstrate that, for the relevant reporting period, 3,000 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing MRI providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-180. Staffing.

MRI services should be under the direct supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 3. Magnetic Source Imaging

12VAC5-230-190. Policy for the development of MSI services.

Because Magnetic Source Imaging (MSI) scanning systems are still in the clinical research stage of development with no third-party payment available for clinical applications, and because it is uncertain as to how rapidly this technology will reach a point where it is shown to be clinically suitable for widespread use and distribution on a cost-effective basis, it is preferred that the entry and development of this technology in Virginia should initially occur at or in affiliation with, the academic medical centers in the state.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 4. Positron Emission Tomography

12VAC5-230-200. Travel time.

PET services should be within 60 minutes driving time one way under normal conditions of 95% of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-210. Need for new fixed site service.

A. If the applicant is a hospital, whether free-standing or within a hospital system, 850 new PET appropriate cases shall have been diagnosed and the hospital shall have provided radiation therapy services with specific ancillary services suitable for the equipment before a new fixed site PET service should be approved for the health planning district.

B. No new fixed site PET services should be approved unless an average of 6,000 procedures per existing and approved fixed site PET scanner were performed in the health planning district during the relevant reporting period and the proposed new service would not significantly reduce the utilization of existing fixed site PET providers in the health planning district . The utilization of existing scanners operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of PET units in such health planning district.

Note: For the purposes of tracking volume utilization, an image taken with a PET/CT scanner that takes concurrent PET/CT images shall be counted as one PET procedure. Images made with PET/CT scanners that can take PET or CT images independently shall be counted as individual PET procedures and CT procedures respectively, unless those images are made concurrently.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-220. Expansion of fixed site services.

Proposals to increase the number of PET scanners in an existing PET service should be approved only when the existing scanners performed an average of 6,000 procedures for the relevant reporting period and the proposed expansion would not significantly reduce the utilization of existing fixed site providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-230. Adding or expansing mobile PET or PET/CT services.

A. Proposals for mobile PET or PET/CT scanners should demonstrate that, for the relevant reporting period, at least 230 PET or PET/CT appropriate patients were seen and that the proposed mobile unit will not significantly reduce the utilization of existing providers in the health planning district.

B. Proposals to convert authorized mobile PET or PET/CT scanners to fixed site scanners should demonstrate that, for the relevant reporting period, at least 1,400 procedures were performed by the mobile scanner and that the proposed conversion will not significantly reduce the utilization of existing providers in the health planning district .

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-240. Staffing.

PET services should be under the direction or supervision of one or more qualified physicians. Such physicians shall be designated or authorized by the Nuclear Regulatory Commission or licensed by the Division of Radiologic Health of the Virginia Department of Health, as applicable.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 5. Noncardiac Nuclear Imaging Criteria and Standards

12VAC5-230-250. Travel time.

Noncardiac nuclear imaging services should be available within 30 minutes driving time one way under normal driving conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-260. Need for new service.

No new noncardiac imaging services should be approved unless the service can achieve a minimum utilization level of:

1. 650 procedures in the first 12 months of operation;

2. 1,000 procedures in the second 12 months of service; and

3. The proposed new service would not significantly reduce the utilization of existing providers in the health planning district.

Note: The utilization of an existing service operated by a hospital and serving an area distinct from the proposed new service site may be disregarded in computing the average utilization of noncardiac nuclear imaging services in such health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-270. Staffing.

The proposed new or expanded noncardiac nuclear imaging service should be under the direction or supervision of one or more qualified physicians designated or authorized by the Nuclear Regulatory Commission or the Division of Radiologic Health of the Virginia Department of Health, as applicable.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part III. Radiation Therapy Services

Article 1. Radiation Therapy Services

12VAC5-230-280. Travel time.

Radiation therapy services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-290. Need for new service.

A. No new radiation therapy service should be approved unless:

1. Existing radiation therapy machines located in the health planning district performed an average of 8,000 procedures per existing and approved radiation therapy machine in the relevant reporting period; and

2. The new service will perform at least 5,000 procedures by the second year of operation without significantly reducing the utilization of existing providers in the health planning district.

B. The number of radiation therapy machines needed in a health planning district will be determined as follows:

$$\frac{\text{Population x Cancer Incidence Rate x } 60\%}{320}$$

where:

1. The population is projected to be at least 150,000 people three years from the current year as reported in the most current projections of a demographic entity as determined by the commissioner;

2. The cancer incidence rate as determined by data from the Statewide Cancer Registry;

3. 60% is the estimated number of new cancer cases in a health planning district that are treatable with radiation therapy; and

4. 320 is 100% utilization of a radiation therapy machine based upon an anticipated average of 25 procedures per case.

C. Proposals for new radiation therapy services located less than 60 minutes driving time one way, under normal conditions, from any site that radiation therapy services are available shall demonstrate that the proposed new services will perform an average of 4,500 procedures annually by the second year of operation, without significantly reducing the utilization of existing services in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-300. Expansion of service.

Proposals to expand radiation therapy services should be approved only when all existing radiation therapy services operated by the applicant in the health planning district have performed an average of 8,000 procedures for the relevant reporting period and the proposed expansion would not significantly reduce the utilization of existing providers.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-310. Statewide Cancer Registry.

Facilities with radiation therapy services shall participate in the Statewide Cancer Registry as required by Article 9 (§ 32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-320. Staffing.

Radiation therapy services should be under the direction or supervision of one or more qualified physicians designated or authorized by the Nuclear Regulatory Commission or the Division of Radiologic Health of the Virginia Department of Health, as applicable.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 2. Criteria and Standards for Stereotactic Radiosurgery

12VAC5-230-330. Travel time.

Stereotactic radiosurgery services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of a health planning region using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-340. Need for new service.

A. No new stereotactic radiosurgery services should be approved unless:

1. The number of procedures performed with existing units in the health planning region averaged more than 350 per year in the relevant reporting period; and

2. The proposed new service will perform at least 250 procedures in the second year of operation without significantly reducing the utilization of existing providers in the health planning region.

B. Preference may be given to a project that incorporates stereotactic radiosurgery service incorporated within an existing standard radiation therapy service using a linear accelerator when an average of 8,000 procedures during the relevant reporting period and utilization of existing services in the health planning region will not be significantly reduced.

C. Preference may be given to a project that incorporates a dedicated Gamma Knife® within an existing radiation therapy service when:

1. At least 350 Gamma Knife® appropriate cases were referred out of the region in the relevant reporting period; and

2. The applicant can demonstrate that:

a. An average of 250 procedures will be preformed in the second year of operation; and

b. Utilization of existing services in the health planning region will not be significantly reduced.

D. Preference may be given to a project that incorporates non-Gamma Knife® SRS technology within an existing radiation therapy service when:

1. The unit is not part of a linear accelerator;

2. An average of 8,000 radiation procedures per year were performed by the existing radiation therapy services;

3. At least 250 procedures will be performed within the second year of operation; and

4. Utilization of existing services in the health planning region will not be significantly reduced.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-350. Expansion of service.

Proposals to increase the number of stereotactic radiosurgery services should be approved only when all existing stereotactic radiosurgery machines in the health planning region have performed an average of 350 procedures per existing and approved unit for the relevant reporting

period and the proposed expansion would not significantly reduce the utilization of existing providers in the health planning region.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-360. Statewide Cancer Registry.

Facilities with stereotactic radiosurgery services shall participate in the Statewide Cancer Registry as required by Article 9 (§ 32.1-70 et seq.) of Chapter 2 of Title 32.1 of the Code of Virginia.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-370. Staffing.

Stereotactic radiosurgery services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part IV. Cardiac Services

Article 1. Criteria and Standards for Cardiac Catheterization Services

12VAC5-230-380. Travel time.

Cardiac catheterization services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-390. Need for new service.

A. No new fixed site cardiac catheterization service should be approved for a health planning district unless:

1. Existing fixed site cardiac catheterization services located in the health planning district performed an average of 1,200 cardiac catheterization DEPs per existing and approved laboratory for the relevant reporting period;

2. The proposed new service will perform an average of 200 DEPs in the first year of operation and 500 DEPs in the second year of operation; and

3. The utilization of existing services in the health planning district will not be significantly reduced.

B. Proposals for mobile cardiac catheterization laboratories should be approved only if such laboratories will be provided at a site located on the campus of an inpatient hospital. Additionally, applicants for proposed mobile cardiac catheterization laboratories shall be able to project that they will perform an average of 200 DEPs in the first year of operation and 350 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district below 1,200 procedures.

C. Preference may be given to a project that locates new cardiac catheterization services at an inpatient hospital that is 60 minutes or more driving time one way under normal conditions from existing services if the applicant can demonstrate that the proposed new laboratory will perform an average of 200 DEPs in the first year of operation and 400 DEPs in the second year of operation without significantly reducing the utilization of existing laboratories in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-400. Expansion of services.

Proposals to increase cardiac catheterization services should be approved only when:

1. All existing cardiac catheterization laboratories operated by the applicant's facilities where the proposed expansion is to occur have performed an average of 1,200 DEPs per existing and approved laboratory for the relevant reporting period; and

2. The applicant can demonstrate that the expanded service will achieve an average of 200 DEPs per laboratory in the first 12 months of operation and 400 DEPs in the second 12 months of operation without significantly reducing the utilization of existing cardiac catheterization laboratories in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-410. Pediatric cardiac catheterization.

No new or expanded pediatric cardiac catheterization services should be approved unless:

1. The proposed service will be provided at an inpatient hospital with open heart surgery services, pediatric tertiary care services or specialty or subspecialty level neonatal special care;

2. The applicant can demonstrate that the proposed laboratory will perform at least 100 pediatric cardiac catheterization procedures in the first year of operation and 200 pediatric cardiac catheterization procedures in the second year of operation; and

3. The utilization of existing pediatric cardiac catheterization laboratories in the health planning district will not be reduced below 100 procedures per year.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-420. Nonemergent cardiac catheterization.

A. Simple therapeutic cardiac catheterization. Proposals to provide simple therapeutic cardiac catheterization are not required to offer open heart surgery service available on-site in the same hospital in which the proposed simple therapeutic service will be located. However, these programs shall adhere to the requirements described in subdivisions 1 through 9 of this subsection.

The programs shall:

1. Participate in the Virginia Heart Attack Coalition, the Virginia Cardiac Services Quality Initiative, and the Action Registry-Get with the Guidelines or National Cardiovascular Data Registry to monitor quality and outcomes;

2. Adhere to strict patient-selection criteria;

3. Perform annual institutional volumes of 300 cardiac catheterization procedures, of which at least 75 should be percutaneous coronary intervention (PCI) or as dictated by American College of Cardiology (ACC)/American Heart Association (AHA) Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories effective 1991;

4. Use only AHA/ACC-qualified operators who meet the standards for training and competency;

5. Demonstrate appropriate planning for program development and complete both a primary PCI development program and an elective PCI development program that includes routine care process and case selection review;

6. Develop and maintain a quality and error management program;

7. Provide PCI 24 hours a day, seven days a week;

8. Develop and maintain necessary agreements with a tertiary facility that must agree to accept emergent and nonemergent transfers for additional medical care, cardiac surgery, or intervention; and

9. Develop and maintain agreements with an ambulance service capable of advanced life support and intra-aortic balloon pump transfer that guarantees a 30-minute or less response time.

B. Complex therapeutic cardiac catheterization. Proposals to provide complex therapeutic cardiac catheterization should be approved only when open heart surgery services are available on-site in the same hospital in which the proposed complex therapeutic service will be located. Additionally, these complex therapeutic cardiac catheterization programs will be required to participate in the Virginia Cardiac Services Quality Initiative and the Virginia Heart Attack Coalition.

Statutory Authority

§§32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 37, Issue 14, eff. March 31, 2021.

12VAC5-230-430. Staffing.

A. Cardiac catheterization services should have a medical director who is board certified in cardiology and has clinical experience in performing physiologic and angiographic procedures.

In the case of pediatric cardiac catheterization services, the medical director should be board-certified in pediatric cardiology and have clinical experience in performing physiologic and angiographic procedures.

B. Cardiac catheterization services should be under the direct supervision or one or more qualified physicians. Such physicians should have clinical experience in performing physiologic and angiographic procedures.

Pediatric catheterization services should be under the direct supervision of one or more qualified physicians. Such physicians should have clinical experience in performing pediatric physiologic and angiographic procedures.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 2. Criteria and Standards for Open Heart Surgery

12VAC5-230-440. Travel time.

A. Open heart surgery services should be within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

B. Such services shall be available 24 hours a day, seven days a week.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-450. Need for new service.

A. No new open heart services should be approved unless:

1. The service will be available in an inpatient hospital with an established cardiac catheterization service that has performed an average of 1,200 DEPs for the relevant reporting period and has been in operation for at least 30 months;

2. Open heart surgery services located in the health planning district performed an average of 400 open heart and closed heart surgical procedures for the relevant reporting period; and

3. The proposed new service will perform at least 150 procedures per room in the first year of operation and 250 procedures per room in the second year of operation without significantly reducing the utilization of existing open heart surgery services in the health planning district.

B. Preference may be given to a project that locates new open heart surgery services at an inpatient hospital more than 60 minutes driving time one way under normal condition from any site in which open heart surgery services are currently available and:

1. The proposed new service will perform an average of 150 open heart procedures in the first year of operation and 200 procedures in the second year of operation without significantly reducing the utilization of existing open heart surgery rooms within two hours driving time one way under normal conditions from the proposed new service location below 400 procedures per room; and

2. The hospital provided an average of 1,200 cardiac catheterization DEPs during the relevant reporting period in a service that has been in operation at least 30 months.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-460. Expansion of service.

Proposals to expand open heart surgery services shall demonstrate that existing open heart surgery rooms operated by the applicant have performed an average of:

1. 400 adult equivalent open heart surgery procedures in the relevant reporting period if the proposed increase is within one hour driving time one way under normal conditions of an existing open heart surgery service; or

2. 300 adult equivalent open heart surgery procedures in the relevant reporting period if the proposed service is in excess of one hour driving time one way under normal conditions of an existing open heart surgery service in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-470. Pediatric open heart surgery services.

No new pediatric open heart surgery service should be approved unless the proposed new service is provided at an inpatient hospital that:

1. Has pediatric cardiac catheterization services that have been in operation for 30 months and have performed an average of 200 pediatric cardiac catheterization procedures for the relevant reporting period; and

2. Has pediatric intensive care services and provides specialty or subspecialty neonatal special care.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-480. Staffing.

A. Open heart surgery services should have a medical director who is board certified in cardiovascular or cardiothoracic surgery by the appropriate board of the American Board of Medical Specialists.

In the case of pediatric cardiac surgery, the medical director should be board certified in cardiovascular or cardiothoracic surgery, with special qualifications and experience in pediatric cardiac surgery and congenital heart disease, by the appropriate board of the American Board of Medical Specialists.

B. Cardiac surgery should be under the direct supervision of one or more qualified physicians.

Pediatric cardiac surgery services should be under the direct supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part V. General Surgical Services

12VAC5-230-490. Travel time.

Surgical services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the health planning district using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-500. Need for new service.

A. The combined number of inpatient and outpatient general purpose surgical operating rooms needed in a health planning district, exclusive of procedure rooms, dedicated cesarean section rooms, operating rooms designated exclusively for cardiac surgery, procedures rooms or VDH-designated trauma services, shall be determined as follows:

$$FOR = \frac{((ORV/POP) \times (PROPOP)) \times AHORV}{1600}$$

Where:

ORV = the sum of total inpatient and outpatient general purpose operating room visits in the health planning district in the most recent five years for which general purpose operating room utilization data has been reported by VHI; and

POP = the sum of total population in the health planning district as reported by a demographic entity as determined by the commissioner, for the same five-year period as used in

determining ORV.

PROPOP = the projected population of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

AHORV = the average hours per general purpose operating room visit in the health planning district for the most recent year for which average hours per general purpose operating room visits have been calculated as reported by VHI.

FOR = future general purpose operating rooms needed in the health planning district five years from the current year.

1600 = available service hours per operating room per year based on 80% utilization of an operating room available 40 hours per week, 50 weeks per year.

B. Projects involving the relocation of existing operating rooms within a health planning district may be authorized when it can be reasonably documented that such relocation will: (i) improve the distribution of surgical services within a health planning district ; (ii) result in the provision of the same surgical services at a lower cost to surgical patients in the health planning district; or (iii) optimize the number of operations in the health planning district that are performed on an outpatient basis.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-510. Staffing.

Surgical services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part VI. Inpatient Bed Requirements

12VAC5-230-520. Travel time.

Inpatient beds should be within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using a mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-530. Need for new service.

A. No new inpatient beds should be approved in any health planning district unless:

1. The resulting number of beds for each bed category contained in this article does not exceed the number of beds projected to be needed for that health planning district for the fifth planning horizon year; and

2. The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:

a. 80% at midnight census for medical/surgical or pediatric beds;

b. 65% at midnight census for intensive care beds.

B. For proposals to convert under-utilized beds that require a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection C of this section, consideration may be given to such proposal if:

1. There is a projected need in the applicable category of inpatient beds; and

2. The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.

For the purposes of this part, "underutilized" means less than 80% average annual occupancy for medical/surgical or pediatric beds, when the relocation involves such beds and less than 65% average annual occupancy for intensive care beds when relocation involves such beds.

C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

A x (1+B)

where:

A = the capital expenditure threshold amount for the previous year

and

B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 30, Issue 8, eff. February 4, 2014.

12VAC5-230-540. Need for medical/surgical beds.

The number of medical/surgical beds projected to be needed in a health planning district shall be computed as follows:

1. Determine the use rate for the medical/surgical beds for the health planning district using the formula:

BUR = (IPD/PoP)

Where:

BUR = the bed use rate for the health planning district.

IPD = the sum of total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

PoP = the sum of total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of medical/surgical beds needed for the health planning district in five years from the current year using the formula:

ProBed = ((BUR x ProPop)/365)/0.80

Where:

ProBed = The projected number of medical/surgical beds needed in the health planning district for five years from the current year.

BUR = the bed use rate for the health planning district determined in subdivision 1 of this section.

ProPop = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of medical/surgical beds that are needed in the health planning district for the five planning horizon years as follows:

NewBed = ProBed – CurrentBed

Where:

NewBed = the number of new medical/surgical beds that can be established in a health planning district, if the number is positive. If NewBed is a negative number, no additional medical/surgical beds should be authorized for the health planning district.

ProBed = the projected number of medical/surgical beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentBed = the current inventory of licensed and authorized medical/surgical beds in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 25, Issue 13, eff. April 1, 2009.

12VAC5-230-550. Need for pediatric beds.

The number of pediatric beds projected to be needed in a health planning district shall be computed as follows:

1. Determine the use rate for pediatric beds for the health planning district using the formula:

PBUR = (PIPD/PedPop)

Where:

PBUR = The pediatric bed use rate for the health planning district.

PIPD = The sum of total pediatric inpatient days in the health planning district for the most recent five years for which inpatient days data has been reported by VHI; and

PedPop = The sum of population under 18 years of age in the health planning district for the same five years used to determine PIPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of pediatric beds needed to the health planning district in five years from the current year using the formula:

ProPedBed = ((PBUR x ProPedPop)/365)/0.80

Where:

ProPedBed = The projected number of pediatric beds needed in the health planning district for five years from the current year.

PBUR = The pediatric bed use rate for the health planning district determined in subdivision 1 of this section.

ProPedPop = The projected population under 18 years of age of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of pediatric beds needed within thehealth planning district for the

fifth planning horizon year as follows:

NewPedBed – ProPedBed – CurrentPedBed

Where:

NewPedBed = the number of new pediatric beds that can be established in a health planning district, if the number is positive. If NewPedBed is a negative number, no additional pediatric beds should be authorized for the health planning district.

ProPedBed = the projected number of pediatric beds needed in the health planning district for five years from the current year determined in subdivision 2 of this section.

CurrentPedBed = the current inventory of licensed and authorized pediatric beds in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 25, Issue 13, eff. April 1, 2009.

12VAC5-230-560. Need for intensive care beds.

The projected need for intensive care beds in a health planning district shall be computed as follows:

1. Determine the use rate for ICU beds for the health planning district using the formula:

ICUBUR = (ICUPD/Pop)

Where:

ICUBUR = The ICU bed use rate for the health planning district.

ICUPD = The sum of total ICU inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported by VHI; and

Pop = The sum of population 18 years of age or older for adults or under 18 for pediatric patients in the health planning district for the same five years used to determine ICUPD as reported by a demographic program as determined by the commissioner.

2. Determine the total number of ICU beds needed for the health planning district, including bed availability for unscheduled admissions, five years from the current year using the formula:

ProICUBed = ((ICUBUR x ProPop)/365)/0.65

Where:

ProICUBed = The projected number of ICU beds needed in the health planning district for

five years from the current year;

ICUBUR = The ICU bed use rate for the health planning district as determine in subdivision 1 of this section;

ProPop = The projected population 18 years of age or older for adults or under 18 for pediatric patients of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

3. Determine the number of ICU beds that may be established or relocated within the health planning district for the fifth planning horizon planning year as follows:

NewICUB = ProICUBed – CurrentICUBed

Where:

NewICUBed = The number of new ICU beds that can be established in a health planning district, if the number is positive. If NewICUBed is a negative number, no additional ICU beds should be authorized for the health planning district.

ProICUBed = The projected number of ICU beds needed in the health planning district for five years from the current year as determined in subdivision 2 of this section.

CurrentICUBed = The current inventory of licensed and authorized ICU beds in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 25, Issue 13, eff. April 1, 2009.

12VAC5-230-570. Expansion or relocation of services.

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:

1. Off-site replacement is necessary to correct life safety or building code deficiencies;

2. The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;

3. The number of beds to be moved off-site is taken out of service at the existing facility;

4. The off-site replacement of beds results in:

a. A decrease in the licensed bed capacity;

b. A substantial cost savings, cost avoidance, or consolidation of underutilized facilities; or

c. Generally improved operating efficiency in the applicant's facility or facilities; and

5. The relocation results in improved distribution of existing resources to meet community needs.

B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the site of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-580. Long-term acute care hospitals (LTACHs).

A. LTACHs will not be considered as a separate category for planning or licensing purposes. All LTACH beds remain part of the inventory of inpatient hospital beds.

B. A LTACH shall only be approved if an existing hospital converts existing medical/surgical beds to LTACH beds or if there is an identified need for LTACH beds within a health planning district. New LTACH beds that would result in an increase in total licensed beds above 165% of the average daily census for the health planning district will not be approved. Excess inpatient beds within an applicant's existing acute care facilities must be converted to fill any unmet need for additional LTACH beds.

C. If an existing or host hospital converts existing beds for use as LTACH beds, those beds must be delicensed from the bed inventory of the existing hospital. If the LTACH ceases to exist, terminates its services, or does not offer services for a period of 12 months within its first year of operation, the beds delicensed by the host hospital to establish the LTACH shall revert back to that host hospital.

If the LTACH ceases operation in subsequent years of operation, the host hospital may reacquire the LTACH beds by obtaining a COPN, provided the beds are to be used exclusively for their original intended purpose and the application meets all other applicable project delivery requirements. Such an application shall not be subject to the standard batch review cycle and shall be processed as allowed under Part VI (12VAC5-220-280 et seq.) of the Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations.

D. The application shall delineate the service area for the LTACH by documenting the expected areas from which it is expected to draw patients.

E. A LTACH shall be established for 10 or more beds.

F. A LTACH shall become certified by the Centers for Medicare and Medicaid Services (CMS) as a long-term acute care hospital and shall not convert to a hospital for patients needing a length of stay of less than 25 days without obtaining a certificate of public need.

1. If the LTACH fails to meet the CMS requirements as a LTACH within 12 months after

beginning operation, it may apply for a six-month extension of its COPN.

2. If the LTACH fails to meet the CMS requirements as a LTACH within the extension period, then the COPN granted pursuant to this section shall expire automatically.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-590. Staffing.

Inpatient services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part VII. Nursing Facilities

12VAC5-230-600. Travel time.

A. Nursing facility beds should be accessible within 30 minutes driving time one way under normal conditions to 95% of the population in a health planning district using mapping software as determined by the commissioner.

B. Nursing facilities should be accessible by public transportation when such systems exist in an area.

C. Preference may be given to proposals that improve geographic access and reduce travel time to nursing facilities within a health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-610. Need for new service.

A. A health planning district should be considered to have a need for additional nursing facility beds when:

1. The bed need forecast exceeds the current inventory of existing and authorized beds for the

health planning district; and

2. The median annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the health planning district was at least 93%, and the average annual occupancy of all existing and authorized Medicaid-certified nursing facility beds in the health planning district was at least 90%, excluding the bed inventory and utilization of the Virginia Veterans Care Centers.

Exception: When there are facilities that have been in operation less than one year in the health planning district, their occupancy can be excluded from the calculation of average occupancy .

B. No health planning district should be considered in need of additional beds if there are unconstructed beds designated as Medicaid certified. This presumption of "no need" for additional beds extends for three years from the issuance date of the certificate.

C. The bed need forecast will be computed as follows:

PDBN = (UR64 x PP64) + (UR69 x PP69) + (UR74 x PP74) + (UR79 x PP79) + (UR84 x PP84) + (UR85 x PP85)

Where:

PDBN = Planning district bed need.

UR64 = The nursing home bed use rate of the population aged 0 to 64 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP64 = The population aged 0 to 64 projected for thehealth planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR69 = The nursing home bed use rate of the population aged 65 to 69 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP69 = The population aged 65 to 69 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR74 = The nursing home bed use rate of the population aged 70 to 74 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP74 = The population aged 70 to 74 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR79 = The nursing home bed use rate of the population aged 75 to 79 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP79 = The population aged 75 to 79 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR84 = The nursing home bed use rate of the population aged 80 to 84 in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP84 = The population aged 80 to 84 projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

UR85+ = The nursing home bed use rate of the population aged 85 and older in the health planning district as determined in the most recent nursing home patient origin study authorized by VHI.

PP85+ = The population aged 85 and older projected for the health planning district three years from the current year as most recently published by a demographic program as determined by the commissioner.

Health planning district bed need forecasts will be rounded as follows:

Health Planning District Bed Need	Rounded Bed Need
1–29	0
30–44	30
45–84	60
85–104	90
105–134	120
135–164	150
165–194	180
195–224	210
225+	240

Exception: When a health planning district has:

1. Two or more nursing facilities;

2. Had a median annual occupancy rate of 93% of all existing and authorized Medicaid-certified nursing facility beds and an annual average occupancy rate of at least 90% of all existing and authorized Medicaid-certified nursing facility beds for each of the most recent two years for which bed utilization has been reported to VHI; and

3. Has a forecasted bed need of 15 to 29 beds, then the bed need for this health planning district will be rounded to 30.

D. No new freestanding nursing facilities of less than 90 beds should be authorized. However, consideration may be given to a new freestanding facility with fewer than 90 nursing facility beds when the applicant can demonstrate that such a facility is justified based on a locality's preference for such smaller facility and there is a documented poor distribution of nursing facility beds within the health planning district.

E. When evaluating the capital cost of a project, consideration may be given to projects that use the current methodology as determined by the Department of Medical Assistance Services.

F. Preference may be given to projects that replace outdated and functionally obsolete facilities with modern facilities that result in the more cost-efficient resident services in a more aesthetically pleasing and comfortable environment.

Statutory Authority

§§32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 37, Issue 14, eff. March 31, 2021.

12VAC5-230-620. Expansion of services.

Proposals to increase an existing nursing facility's bed capacity should not be approved unless the facility has operated for at least two years and the average annual occupancy of the facility's existing beds was at least 90% in the relevant reporting period as reported to VHI.

Note: Exceptions will be considered for facilities that operated at less than 90% average annual occupancy in the most recent year for which bed utilization has been reported when the facility offers short stay services causing an average annual occupancy lower than 90% for the facility.

Statutory Authority

§§32.1-12 and 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 37, Issue 14, eff. March 31, 2021.

12VAC5-230-630. Continuing care retirement communities.

Proposals for the development of new nursing facilities or the expansion of existing facilities by continuing care retirement communities (CCRC) will be considered when:

1. 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 of the Code of Virginia;

2. The number of nursing facility beds requested in the initial application does not exceed the lesser of 20% of the continuing care retirement community's total number of beds that are not nursing home beds or 60 beds;

3. The number of new nursing facility beds requested in any subsequent application does not cause the continuing care retirement community's total number of nursing home beds to exceed 20% of its total number of beds that are not nursing facility beds; and

4. The continuing care retirement community has established a qualified resident assistance policy.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-640. Staffing.

Nursing facilities shall be under the direction or supervision of a licensed nursing home administrator and staffed by licensed and certified nursing personnel qualified as required by law.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part VIII. Lithotripsy Service

12VAC5-230-650. Travel time.

Lithotripsy services should be available within 30 minutes driving time one way under normal conditions for 95% of the population of the health planning region using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-660. Need for new service.

A. Preference may be given to a project that establishes new renal or orthopedic lithotripsy services at a new facility through contract with, or by lease of equipment from, an existing service provider authorized to operate in Virginia, and the facility has referred at least two appropriate patients per week, or 100 appropriate patients annually, for the relevant reporting period to other facilities for either renal or orthopedic lithotripsy services.

B. A new renal lithotripsy service may be approved if the applicant can demonstrate that the proposed service can provide at least 750 renal lithotripsy procedures annually.

C. A new orthopedic lithotripsy service may be approved if the applicant can demonstrate that the proposed service can provide at least 500 orthopedic lithotripsy procedures annually.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-670. Expansion of services.

A. Proposals to expand renal lithotripsy services should demonstrate that each existing unit owned or operated by that vendor or provider has provided at least 750 procedures annually at all sites served by the vendor or provider.

B. Proposals to expand orthopedic lithotripsy services should demonstrate that each existing unit owned or operated by that vendor or provider has provided at least 500 procedures annually at all sites served by the vendor or provider.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-680. Adding or expanding mobile lithotripsy services.

A. Proposals for mobile lithotripsy services should demonstrate that, for the relevant reporting period, at least 125 procedures were performed and that the proposed mobile unit will not reduce the utilization of existing machines in the health planning region.

B. Proposals to convert a mobile lithotripsy service to a fixed site lithotripsy service should demonstrate that, for the relevant reporting period, at least 430 procedures were performed and the proposed conversion will not reduce the utilization of existing providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-690. Staffing.

Lithotripsy services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part IX. Organ Transplant

12VAC5-230-700. Travel time.

A. Organ transplantation services should be accessible within two hours driving time one way under normal conditions of 95% of Virginia's population using mapping software as determined by the commissioner.

B. Providers of organ transplantation services should facilitate access to pre and post transplantation services needed by patients residing in rural locations be establishing part-time satellite clinics.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-710. Need for new service.

A. There should be no more than one program for each transplantable organ in a health planning region.

B. Performance of minimum transplantation volumes as cited in 12VAC5-230-720 does not indicate a need for additional transplantation capacity or programs.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-720. Transplant volumes; survival rates; service proficiency; systems operations.

A. Proposals to establish organ transplantation services should demonstrate that the minimum number of transplants would be performed annually. The minimum number transplants of required by organ system is:

Kidney	30
Pancreas or kidney/pancreas	12
Heart	17
Heart/Lung	12
Lung	12
Liver	21

Intestine	2

Note: Any proposed pancreas transplant program must be a part of a kidney transplant program that has achieved a minimum volume standard of 30 cases per year for kidney transplants as well as the minimum transplant survival rates stated in subsection B of this section.

B. Applicants shall demonstrate that they will achieve and maintain at least the minimum transplant patient survival rates. Minimum one-year survival rates listed by organ system are:

Kidney	95%
Pancreas or kidney/pancreas	90%
Heart	85%
Heart/Lung	70%
Lung	77%
Liver	86%
Intestine	77%

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-730. Expansion of transplant services.

A. Proposals to expand organ transplantation services shall demonstrate at least two years successful experience with all existing organ transplantation systems at the hospital.

B. Preference may be given to a project expanding the number of organ systems being transplanted at a successful existing service rather than developing new programs that could reduce existing program volumes.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-740. Staffing.

Organ transplant services should be under the direct supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part X. Miscellaneous Capital Expenditures

12VAC5-230-750. Purpose.

This part of the SMFP is intended to provide general guidance in the review of projects that require COPN authorization by virtue of their expense but do not involve changes in the bed or service capacity of a medical care facility addressed elsewhere in this chapter. This part may be used in coordination with other service specific parts addressed elsewhere in this chapter.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-760. Project need.

12VAC5-230-760. Project need.

A. All applications involving a capital expenditure with an expenditure exceeding the threshold amount as determined using the formula contained in subsection B of this section by a medical care facility should include documentation that the expenditure is necessary in order for the facility to meet the identified medical care needs of the public it serves. Such documentation should clearly identify that the expenditure:

1. Represents the most cost-effective approach to meeting the identified need; and

2. The ongoing operational costs will not result in unreasonable increases in the cost of delivering the services provided.

B. The capital expenditure threshold referenced in subsection A of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

A x (1+B)

where:

A = the capital expenditure threshold amount for the previous year

and

B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; amended, Virginia Register Volume 30, Issue 8, eff. February 4, 2014.

12VAC5-230-770. Facilities expansion.

Applications for the expansion of medical care facilities should document that the current space provided in the facility for the areas or departments proposed for expansion is inadequate. Such documentation should include:

1. An analysis of the historical volume of work activity or other activity performed in the area or department;

2. The projected volume of work activity or other activity to be performed in the area or department; and

3. Evidence that contemporary design guidelines for space in the relevant areas or departments, based on levels of work activity or other activity, are consistent with the proposal.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-780. Renovation or modernization.

A. Applications for the renovation or modernization of medical care facilities should provide documentation that:

1. The timing of the renovation or modernization expenditure is appropriate within the life cycle of the affected building or buildings; and

2. The benefits of the proposed renovation or modernization will exceed the costs of the renovation or modernization over the life cycle of the affected building or buildings to be renovated or modernized.

B. Such documentation should include a history of the affected building or buildings, including a chronology of major renovation and modernization expenses.

C. Applications for the general renovation or modernization of medical care facilities should include downsizing of beds or other service capacity when such capacity has not operated at a reasonable level of efficiency as identified in the relevant sections of this chapter during the most recent five-year period.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-790. Equipment.

Applications for the purchase and installation of equipment by medical care facilities that are not addressed elsewhere in this chapter should document that the equipment is needed. Such documentation should clearly indicate that the (i) proposed equipment is needed to maintain the current level of service provided, or (ii) benefits of the change in service resulting from the new equipment exceed the costs of purchasing or leasing and operating the equipment over its useful life.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part XI. Medical Rehabilitation

12VAC5-230-800. Travel time.

Medical rehabilitation services should be available within 60 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-810. Need for new service.

A. The number of comprehensive and specialized rehabilitation beds shall be determined as follows:

((UR x PROPOP)/365)/.80

Where:

UR = the use rate expressed as rehabilitation patient days per population in the health planning district as reported by VHI; and

PROPOP = the most recent projected population of the health planning district five years from the current year as published by a demographic entity as determined by the commissioner.

B. Proposals for new medical rehabilitation beds should be considered when the applicant can demonstrate that:

1. The rehabilitation specialty proposed is not currently offered in the health planning district; and

2. There is a documented need for the service or beds in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-820. Expansion of services.

No additional rehabilitation beds should be authorized for a health planning district in which existing rehabilitation beds were utilized with an average annual occupancy of less than 80% in the most recently reported year.

Preference may be given to a project to expand rehabilitation beds by converting underutilized medical/surgical beds.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-830. Staffing.

Medical rehabilitation facilities should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part XII. Mental Health Services

Article 1. Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

12VAC5-230-840. Travel time.

Acute psychiatric and acute substance abuse disorder treatment services should be available

within 60 minutes driving time one way under normal conditions of 95% of the population using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-850. Continuity; integration.

A. Existing and proposed acute psychiatric and acute substance abuse disorder treatment providers shall have established plans for the provision of services to indigent patients that include:

1. The minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients;

2. The minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation;

3. The minimum number of unreimbursed patient days to be provided to local community services boards; and

4. A description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days.

B. Proposed acute psychiatric and acute substance abuse disorder treatment providers shall have formal agreements with the appropriate local community services boards or behavioral health authority that:

1. Specify the number of patient days that will be provided to the community service board;

2. Describe the mechanisms to monitor compliance with charity care provisions;

3. Provide for effective discharge planning for all patients, including return to the patient's place of origin or home state if not Virginia; and

4. Consider admission priorities based on relative medical necessity.

C. Providers of acute psychiatric and acute substance abuse disorder treatment serving large geographic areas should establish satellite outpatient facilities to improve patient access where appropriate and feasible.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-860. Need for new service.

A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period; and

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) have been converted to other uses; (iii) have been vacant for six months or more; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours.

B. Subject to the provisions of 12VAC5-230-70,no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology.

Preference may also be given to the addition of acute psychiatric or acute substance abuse beds dedicated for the treatment of geriatric patients in health planning districts with an excess supply of beds when such additions are justified on the basis of the specialized treatment needs of geriatric patients.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning region in which the health planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period;

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

E. Preference may be given to the development of needed acute psychiatric beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and that have contractual agreements to serve populations served by community services boards, whether through conversion of underutilized general hospital beds or development of new beds.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 2. Mental Retardation

12VAC5-230-870. Need for new service.

The establishment of new ICF/MR facilities with more than 12 beds shall not be authorized unless the following conditions are met:

1. Alternatives to the proposed service are not available in the area to be served by the new facility;

2. There is a documented source of referrals for the proposed new facility;

3. The manner in which the proposed new facility fits into the continuum of care for the mentally retarded is identified;

4. There are distinct and unique geographic, socioeconomic, cultural, transportation, or other factors affecting access to care that require development of a new ICF/MR;

5. Alternatives to the development of a new ICF/MR consistent with the Medicaid waiver program have been considered and can be reasonably discounted in evaluating the need for the new facility;

6. The proposed new facility will have a maximum of 20 beds and is consistent with any plan of the Department of Mental Health, Mental Retardation and Substance Abuse Services and the mental retardation service priorities for the catchment area identified in the plan;

7. Ancillary and supportive services needed for the new facility are available; and

8. Service alternatives for residents of the proposed new facility who are ready for discharge from the ICF/MR setting are available.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009; Errata, 25:11 VA.R. 2018 February 2, 2009.

12VAC5-230-880. Continuity; integration.

Each facility should have a written transfer agreement with one or more hospitals for the transfer of emergency cases if such hospitalization becomes necessary.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-890. Compliance with licensure standards.

Mental retardation facilities should meet all applicable licensure standards as specified in 12VAC35-105, Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Part XIII. Perinatal and Obstetrical Services

Article 1. Criteria and Standards for Obstetrical Services

12VAC5-230-900. Travel time.

Obstetrical services should be located within 30 minutes driving time one way under normal conditions of 95% of the population of the health planning district using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-910. Need for new service.

No new obstetrical services should be approved unless the applicant can demonstrate that, based on the population and utilization of current services, there is a need for such services in the health planning district without significantly reducing the utilization of existing providers in the health planning district.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-920. Continuity.

A. Perinatal service capacity, including service availability for unscheduled admissions, should be developed to provide routine newborn care to infants delivered in the associated obstetrics service, and shall be able to stabilize and prepare for transport those infants requiring the care of a neonatal special care services unit.

B. The proposal shall identify the primary and secondary neonatal special care center nearest the proposed service shall provide transport one-way to those centers.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-930. Staffing.

Obstetric services should be under the direction or supervision of one or more qualified physicians.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Article 2. Neonatal Special Care Services

12VAC5-230-940. Travel time.

A. Intermediate level neonatal special care services should be located within 30 minutes driving time one way under normal conditions of hospitals providing general level new born services using mapping software as determined by the commissioner.

B. Specialty and subspecialty neonatal special care services should be located within 90 minutes driving time one way under normal conditions of hospitals providing general or intermediate level newborn services using mapping software as determined by the commissioner.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-950. Need for new service.

No new level of neonatal service shall be offered by a hospital unless that hospital has first obtained a COPN granting approval to provide each such level of service.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-960. Intermediate level newborn services.

A. Existing intermediate level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new intermediate level newborn services can be added to the health planning region.

B. Intermediate level newborn services as designated in 12VAC5-410-443 should contain a minimum of six bassinets.

C. No more than four bassinets for intermediate level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-970. Specialty level newborn services.

A. Existing specialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new specialty level newborn services can be added to the

health planning region.

B. Specialty level newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets .

C. No more than four bassinets for specialty level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

D. Proposals to establish specialty level services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing specialty level newborn service providers located within the travel time listed in 12VAC5-230-940 will not be significantly reduced.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-980. Subspecialty level newborn services.

A. Existing subspecialty level newborn services as designated in 12VAC5-410-443 should achieve 85% average annual occupancy before new subspecialty level newborn services can be added to the health planning region.

B. Subspecialty level newborn services as designated in 12VAC5-410-443 should contain a minimum of 18 bassinets .

C. No more than four bassinets for subspecialty level newborn services as designated in 12VAC5-410-443 per 1,000 live births should be established in each health planning region.

D. Proposals to establish subspecialty level newborn services as designated in 12VAC5-410-443 shall demonstrate that service volumes of existing subspecialty level newborn providers located within the travel time listed in 12VAC5-230-940 will not be significantly reduced.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-990. Neonatal services.

The application shall identify the service area and the levels of service of all the hospitals to be served by the proposed service.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

12VAC5-230-1000. Staffing.

All levels of neonatal special care services should be under the direction or supervision of one or more qualified physicians as described in 12VAC5-410-443.

Statutory Authority

§ 32.1-102.2 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 25, Issue 9, eff. February 15, 2009.

Documents Incorporated by Reference (12VAC5-230).

ACC/AHA Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories, American College of Cardiology/American Heart Association Ad Hoc Task Force on Cardiac Catheterization, JACC Vol. 18 No. 5, November 1, 1991: 1149-82

Statutory Authority

Historical Notes