WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1987

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ENROLLED

Com. Sub. for

HOUSE BILL No. 2342

(By Delegate Knight)

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Passed March 14, 1987

In Effect Ninety Days From Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2342

(By DELEGATE KNIGHT)

[Passed March 14, 1987; in effect ninety days from passage.]

AN ACT to repeal section six, article twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact sections two, four, five and seven, article two-d; to further amend said article two-d by adding thereto a new section, designated section five-a; to amend and reenact sections eleven, nineteen, twenty, twenty-one and twenty-eight, article twenty-nine-b, all of said chapter sixteen, all relating to continuing and reestablishing the health care cost review authority with certain modifications in its functions; definitions; deleting certain references to federal act; changing expenditure minimums for certificate of need review; allowing certain exemptions from certificate of need review; charging of fees for certain requests for certificate of need review; certificate of need fund; transferring health planning functions to the department of health; state health plan; creating health care planning council; eliminating health care cost review council; regional health advisory councils; temporary moratorium on construction of long-term care beds; rate setting powers; automatic approval of rate increases under certain circumstances; procedure for obtaining adjustments and revisions of rate schedules; permitting

immediate implementation of temporary rate change in certain cases; and termination date.

Be it enacted by the Legislature of West Virginia:

That section six, article twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be repealed; that sections two, four, five and seven, article two-d be amended and reenacted; that article two-d be further amended by adding thereto a new section, designated section five-a; that sections, eleven, nineteen, twenty, twenty-one and twenty-eight, article twenty-nine-b, all of said chapter sixteen, be amended and reenacted, all to read as follows:

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-2. Definitions.

As used in this article, unless otherwise indicated by the context:

(a) "Affected person" means:

(1) The applicant;

(2) An agency or organization representing consumers;

(3) Any individual residing within the geographic area served or to be served by the applicant;

(4) Any individual who regularly uses the health care facilities within that geographic area;

(5) The health care facilities which provide services similar to the services of the facility under review and which will be significantly affected by the proposed project;

(6) The health care facilities which, prior to receipt by the state agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future;

(7) Third party payers who reimburse health care facilities similar to those proposed for services;

(8) Any agency which establishes rates for health care

facilities similar to those proposed; or

(9) Organizations representing health care providers.

(b) "Ambulatory health care facility" means a facility, which is free-standing and not physically attached to a health care facility and which provides health care to noninstitutionalized and nonhomebound persons on an outpatient basis. This definition does not include the private office practice of any one or more health professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code: *Provided*, That such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed.

(c) "Ambulatory surgical facility" means a facility which is free-standing and not physically attached to a health care facility and which provides surgical treatment to patients not requiring hospitalization. This definition does not include the private office practice of any one or more health professionals licensed to practice surgery in this state pursuant to the provisions of chapter thirty of this code: *Provided*, That such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed.

(d) "Applicant" means: (1) The governing body or the person proposing a new institutional health service who is, or will be, the health care facility licensee wherein the new institutional health service is proposed to be located, and (2) in the case of a proposed new institutional health service not to be located in a licensed health care facility, the governing body or the person proposing to provide such new institutional health service. Incorporators or promoters who will not constitute the governing body or persons responsible for the new institutional health service may not be an applicant.

(e) "Bed capacity" means the number of beds for which a license is issued to a health care facility, or, if a facility is unlicensed, the number of adult and pediatric beds permanently staffed and maintained for immediate use by inpatients in patient rooms or wards.

(f) "Capital expenditure" means an expenditure:

(1) Made by or on behalf of a health care facility; and

(2) (A) Which (i) under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or (ii) is made to obtain either by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and (B) which (i) exceeds the expenditure minimum, or (ii) is a substantial change to the bed capacity of the facility with respect to which the expenditure is made, or (iii) is a substantial change to the services of such facility. For purposes of part (i), subparagraph (B), subdivision (2) of this definition, the cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure described in subparagraph (B), subdivision (2) of this definition is made shall be included in determining if such expenditure exceeds the expenditure minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of such subdivisions if a transfer of the equipment or facilities at fair market value would be subject to review. A series of expenditures, each less than the expenditure minimum, which when taken together are in excess of the expenditure minimum, may be determined by the state agency to be a single capital expenditure subject to review. In making its determination, the state agency shall consider: Whether the expenditures are for components of a system which is required to accomplish a single

purpose; whether the expenditures are to be made over a two-year period and are directed towards the accomplishment of a single goal within the health care facility's long-range plan; or, whether the expenditures are to be made within a two-year period within a single department such that they will constitute a significant modernization of the department.

(g) "Expenditure minimum" means one million dollars for the twelve-month period beginning the first day of October, one thousand nine hundred eighty-seven. For each twelve-month period thereafter, the state agency may, by regulations adopted pursuant to section eight of this article, adjust the expenditure minimum to reflect the impact of inflation.

(h) "Health," used as a term, includes physical and mental health.

(i) "Health care facility" is defined as including hospitals, skilled nursing facilities, kidney disease treatment centers, including free-standing hemodialysis units, intermediate care facilities, ambulatory health care facilities, ambulatory surgical facilities, home health agencies, rehabilitation facilities, and health maintenance organizations; community mental health and mental retardation facilities; whether under public or private ownership, or as a profit or nonprofit organization and whether or not licensed or required to be licensed in whole or in part by the state. For purposes of this definition, "community mental health and mental retardation facility" means a private facility which provides such comprehensive services and continuity of care as emergency, outpatient, partial hospitalization, inpatient and consultation and education for individuals with mental illness, mental retardation or drug or alcohol addiction.

(j) "Health care provider" means a person, partnership, corporation, facility or institution licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement.

(k) "Health maintenance organization" means a public or private organization, organized under the laws of this state, which:

(1) Is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act, as amended, Title 42 United States Code Section 300e-9(d); or

(2) (A) Provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: Usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services and out-of-area coverage; and

(B) Is compensated except for copayments for the provision of the basic health care services listed in subparagraph (2)(A), subdivision (m) of this definition to enrolled participants on a predetermined periodic rate basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent or kind of health service actually provided; and

(C) Provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(l) "Health services" means clinically related preventive, diagnostic, treatment or rehabilitative services, including alcohol, drug abuse and mental health services.

(m) "Home health agency" is an organization primarily engaged in providing directly or through contract arrangements, professional nursing services, home health aide services, and other therapeutic and related services including, but not limited to, physical, speech and occupational therapy and nutritional and medical social services to persons in their place of residence on a part-time or intermittent basis.

(n) "Hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. This term also includes psychiatric and tuberculosis hospitals.

(o) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition require health related care and services above the level of room and board.

(p) "Long-range plan" means a document formally adopted by the legally constituted governing body of an existing health care facility or by a person proposing a new institutional health service. Each long-range plan shall consist of the information required by the state agency in regulations adopted pursuant to section eight of this article.

(q) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used for the provision of medical and other health services and which costs in excess of seven hundred fifty thousand dollars, except that such term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs ten and eleven of Section 1861(s) of such act, Title 42 United States Code Sections 1395x (10) and (11). In determining whether medical equipment costs more than seven hundred fifty thousand dollars, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included. If the

equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

(r) "Medically underserved population" means the population of an urban or rural area designated by the state agency as an area with a shortage of personal health services or a population having a shortage of such services, after taking into account unusual local conditions which are a barrier to accessibility or availability of such services. Such designation shall be in regulations adopted by the state agency pursuant to section eight of this article, and the population so designated may include the state's medically underserved population designated by the Federal Secretary of Health and Human Services under Section 330(b)(3) of the Public Health Service Act, as amended, Title 42 United States Code Section 254(b)(3).

(s) "New institutional health service" means such service as described in section three of this article.

(t) "Offer" when used in connection with health services, means that the health care facility or health maintenance organization holds itself out as capable of providing, or as having the means for the provision of, specified health services.

(u) "Person" means an individual, trust, estate, partnership, committee, corporation, association and other organizations such as joint-stock companies and insurance companies, a state or a political subdivision or instrumentality thereof or any legal entity recognized by the state.

(v) "Physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state.

(w) "Proposed new institutional health service" means such service as described in section three of this article.

(x) "Psychiatric hospital" means an institution which primarily provides to inpatients, by or under the supervision of a physician, specialized services for the diagnosis, treatment and rehabilitation of mentally ill and emotionally disturbed persons.

(y) "Rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

(z) "Review agency" means an agency of the state, designated by the governor as the agency for the review of state agency decisions.

(aa) "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(bb) "State agency" means the health care cost review authority created, established, and continued pursuant to article twenty-nine-b of this chapter.

(cc) "State health plan" means the document approved by the governor after preparation by the former statewide health coordinating council, or that document as approved by the governor after amendment by the health care planning council.

(dd) "Health care planning council" means the body established by section five-a of this article to participate in the preparation and amendment of the state health plan and to advise the state agency.

(ee) "Substantial change to the bed capacity" of a health care facility means a change, with which a capital expenditure is associated, in any two-year period of ten or more beds or more than ten percent, whichever is less, of the bed capacity of such facility that increases or decreases the bed capacity, or relocates beds from one physical facility or site to another, but does not include a change by which a health care facility reassigns existing beds as swing beds between acute care and long-term care categories. A series of changes to the bed capacity of a health care facility in any two-year period, each less than ten beds or ten percent of the bed capacity

of such facility, but which when taken together comprise ten or more beds or more than ten percent of the bed capacity of such facility, whichever is less, is a substantial change to the bed capacity.

(ff) "Substantial change to the health services" of a health care facility means the addition of a health service which is offered by or on behalf of the health care facility and which was not offered by or on behalf of the facility within the twelve-month period before the month in which the service is first offered, or the termination of a health service which was offered by or on behalf of the facility, but does not include the providing of hospice care, ambulance service, wellness centers or programs, adult day care, or respite care by acute care facilities.

(gg) "To develop," when used in connection with health services, means to undertake those activities which upon their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, in relation to the offering of such a service.

§16-2D-4. Exemptions from certificate of need program.

(a) Except as provided in subdivision (h), section three of this article, nothing in this article or the rules and regulations adopted pursuant to the provisions of this article may be construed to authorize the licensure, supervision, regulation or control in any manner of: (1) Private office practice of any one or more health professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code: *Provided*, That such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed; (2) dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees: *Provided, however*, That such facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than twenty-

four hours; (3) establishments, such as motels, hotels and boardinghouses, which provide medical, nursing personnel and health related services; and (4) the remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

(b) (1) A certificate of need is not required for the offering of an inpatient institutional health service or the acquisition of major medical equipment for the provision of an inpatient institutional health service or the obligation of a capital expenditure for the provisions of an inpatient institutional health service, if with respect to such offering, acquisition or obligation, the state agency has, upon application under subdivision (2), subsection (b) of this section, granted an exemption to:

(A) A health maintenance organization or a combination of health maintenance organizations if (i) the organization or combination of organizations has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (ii) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination;

(B) A health care facility if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or will be controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations which has, in the service area of the organization or service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (iii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iv) at least seventy-five percent of the patients who can

reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination; or

(C) A health care facility, or portion thereof, if (i) the facility is or will be leased by a health maintenance organization or combination of health maintenance organizations which has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals and on the date the application is submitted under subdivision (2), subsection (b) of this section, at least fifteen years remain in the term of the lease, (ii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the new institutional health service will be individuals enrolled with such organization.

(2) (A) A health maintenance organization, combination of health maintenance organizations, or other health care facility is not exempt under subdivision (1), subsection (b) of this section from obtaining a certificate of need unless:

(i) It has submitted, at such time and in such form and manner as the state agency shall prescribe, an application for such exemption to the state agency;

(ii) The application contains such information respecting the organization, combination or facility and the proposed offering, acquisition or obligation as the state agency may require to determine if the organization or combination meets the requirements of subdivision (1), subsection (b) of this section or the facility meets or will meet such requirements; and

(iii) The state agency approves such application.

(B) The state agency shall approve an application submitted under subparagraph (A), subdivision (2), subsection (b) of this section, if it determines that the applicable requirements of subdivision (1), subsection (b) of this section, are met or will be met on the date

the proposed activity for which an exemption was requested will be undertaken.

(3) A health care facility, or any part thereof, or medical equipment with respect to which an exemption was granted under subdivision (1), subsection (b) of this section, may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired and a health care facility described in subparagraph (C), subdivision (1), subsection (b) of this section, which was granted an exemption under subdivision (1), subsection (b) of this section, may not be used by any person other than the lessee described in subparagraph (C), subdivision (1), subsection (b) of this section, unless:

(A) The state agency issues a certificate of need approving the sale, lease, acquisition or use; or

(B) The state agency determines, upon application, that the entity to which the facility or equipment is proposed to be sold or leased, which intends to acquire the controlling interest in or to use the facility is:

(i) A health maintenance organization or a combination of health maintenance organizations which meets the enrollment requirements of part (i), subparagraph (A), subdivision (1), subsection (b) of this section, and with respect to such facility or equipment, the entity meets the accessibility and patient enrollment requirements of parts (ii) and (iii), subparagraph (A), subdivision (1), subsection (b) of this section; or

(ii) A health care facility which meets the inpatient, enrollment and accessibility requirements of parts (i), (ii) and (iii), subparagraph (B), subdivision (1), subsection (b) of this section and with respect to its patients meets the enrollment requirements of part (iv), subparagraph (B), subdivision (1), subsection (b) of this section.

(4) In the case of a health maintenance organization or an ambulatory care facility or health care facility which ambulatory or health care facility is controlled, directly or indirectly, by a health maintenance organ-

ization or a combination of health maintenance organizations, the certificate of need requirements apply only to the offering of inpatient institutional health services, the acquisition of major medical equipment, and the obligation of capital expenditures for the offering of inpatient institutional health services and then only to the extent that such offering, acquisition or obligation is not exempt under subdivision (1), subsection (b) of this section.

(5) The state agency shall establish the period within which approval or disapproval by the state agency of applications for exemptions under subdivision (1), subsection (b) of this section, shall be made.

(c) (1) A health care facility is not required to obtain a certificate of need for the acquisition of major medical equipment to be used solely for research, the addition of health services to be offered solely for research, or the obligation of a capital expenditure to be made solely for research if the health care facility provides the notice required in subdivision (2), subsection (c) of this section, and the state agency does not find, within sixty days after it receives such notice, that the acquisition, offering or obligation will, or will have the effect to:

(A) Affect the charges of the facility for the provision of medical or other patient care services other than the services which are included in the research;

(B) Result in a substantial change to the bed capacity of the facility; or

(C) Result in a substantial change to the health services of the facility.

(2) Before a health care facility acquires major medical equipment to be used solely for research, offers a health service solely for research, or obligates a capital expenditure solely for research, such health care facility shall notify in writing the state agency of such facility's intent and the use to be made of such medical equipment, health service or capital expenditure.

(3) If major medical equipment is acquired, a health service is offered, or a capital expenditure is obligated

and a certificate of need is not required for such acquisition, offering or obligation as provided in subdivision (1), subsection (c) of this section, such equipment or service or equipment or facilities acquired through the obligation of such capital expenditure may not be used in such a manner as to have the effect or to make a change described in subparagraphs (A), (B) and (C), subdivision (1), subsection (c) of this section unless the state agency issues a certificate of need approving such use.

(4) For purposes of this subsection, the term "solely for research" includes patient care provided on an occasional and irregular basis and not as part of a research program.

(d) (1) The state agency may adopt regulations pursuant to section eight of this article to specify the circumstances under which a certificate of need may not be required for the obligation of a capital expenditure to acquire, either by purchase or under lease or comparable arrangement, an existing health care facility: *Provided*, That a certificate of need shall be required for the obligation of a capital expenditure to acquire, either by purchase or under lease or comparable arrangement, an existing health care facility if:

(A) The notice required by subdivision (2), subsection (d) of this section is not filed in accordance with that subdivision with respect to such acquisition; or (B) the state agency finds, within thirty days after the date it receives a notice in accordance with subdivision (2), subsection (d) of this section, with respect to such acquisition, that the services or bed capacity of the facility will be changed by reason of said acquisition.

(2) Before any person enters into a contractual arrangement to acquire an existing health care facility, such person shall notify the state agency of his or her intent to acquire the facility and of the services to be offered in the facility and its bed capacity. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the facility with respect to which the

notice is given. The notice shall contain all information the state agency requires in accordance with subsections (e) and (s), section seven of this article.

(e) The state agency shall adopt regulations, pursuant to section eight of this article, wherein criteria are established to exempt from review the addition of certain health services, not associated with a capital expenditure, that are projected to entail annual operating costs of less than the expenditure minimum for annual operating costs. For purposes of this subsection, "expenditure minimum for annual operating costs" means five hundred thousand dollars for the twelve-month period beginning the first day of October, one thousand nine hundred eighty-five, and for each twelve-month period thereafter, the state agency may, by regulations adopted pursuant to section eight of this article, adjust the expenditure minimum for annual operating costs to reflect the impact of inflation.

(f) The state agency may adopt regulations pursuant to section eight of this article to specify the circumstances under which and the procedures by which a certificate of need may not be required for the obligation of a capital expenditure to acquire, either by purchase or under lease or comparable arrangement, major medical equipment which merely replaces medical equipment which is already owned by the health care facility and which has become outdated, worn-out, or obsolete.

(g) The state agency may adopt regulations pursuant to section eight of this article to specify the circumstances under which and the procedures by which a certificate of need may not be required for the obligation of a capital expenditure in excess of the expenditure minimum for certain items not directly related to the provision of health services. The state agency shall specify the types of items in the regulations which may be so exempted from review.

(h) The state agency may adopt regulations pursuant to section eight of this article to specify the circumstances under which and the procedures by which a

certificate of need may not be required for shared services between two or more acute care facilities providing services made available through new or existing technology that can reasonably be mobile. The state agency shall specify the types of items in the regulations which may be so exempted from review.

(i) Nothing in this article shall be construed to require the filing of a certificate of need application for any expenditure, health service, or change in health service which is exempt from review under this article. However, the state agency may promulgate rules and regulations pursuant to section eight of this article to require the filing of a notice with the state agency by a health care facility that proposes to make such an expenditure, initiate a health service, or effect a change in a health service for which the health care facility claims an exemption from review. The state agency shall, within ten days of a receipt of such notice, make one of the following responses:

(1) Accept the claim of exemption;

(2) Require the health care facility to furnish the state agency with additional information;

(3) Reject the claim of exemption; or

(4) Determine that a certificate of need application is necessary for a review of the proposed expenditure, new health service, or change in a health service in order to determine if the claim of exemption may be upheld: *Provided*, That when a new health service is proposed to be developed, the state agency shall, within the ten days of receipt of the required notice, determine whether or not economic and geographic factors within the geographic area of the proposed addition to service are such that the proposed new health service will be offered in competition with other health care facilities providing the same or similar service. In the event that an affirmative determination is made on the issue of competition, then the state agency shall require a certificate of need application for the proposed new health service.

§16-2D-5. Powers and duties of state health planning and development agency.

(a) The state agency is hereby empowered to administer the certificate of need program as provided by this article.

(b) The state agency shall cooperate with the health care planning council in developing rules and regulations for the certificate of need program to the extent appropriate for the achievement of efficiency in their reviews and consistency in criteria for such reviews.

(c) The state agency may seek advice and assistance of other persons, organizations, and other state agencies in the performance of the state agency's responsibilities under this article.

(d) For health services for which competition appropriately allocates supply consistent with the state health plan, the state agency shall, in the performance of its functions under this article, give priority, where appropriate to advance the purposes of quality assurance, cost effectiveness, and access, to actions which would strengthen the effect of competition on the supply of such services.

(e) For health services for which competition does not or will not appropriately allocate supply consistent with the state health plan, the state agency shall, in the exercise of its functions under this article, take actions, where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this article, to allocate the supply of such services.

(f) The state agency is hereby empowered to order a moratorium upon the processing of an application or applications for the acquisition of major medical equipment filed pursuant to section three of this article and considered by the agency to be new medical technology, when criteria and guidelines for evaluating the need for such new medical technology have not yet been adopted. Such moratoriums shall be declared by a written order which shall detail the circumstances

requiring the moratorium. Upon the adoption of criteria for evaluating the need for the new medical technology affected by the moratorium, or ninety days from the declaration of a moratorium, whichever is less, the moratorium shall be declared to be over and affected applications shall be processed pursuant to section six of this article.

(g) Notwithstanding the provisions of section seven of this article, the state agency may charge a fee for the filing of any application, the filing of any notice in lieu of an application, the filing of any exemption determination request, or the filing of any request for a declaratory ruling. The fees charged may vary according to the type of matter involved, the type of health service or facility involved, or the amount of capital expenditure involved. The state agency shall implement this subsection by filing procedural rules pursuant to chapter twenty-nine-a of this code. The fees charged shall be deposited into a special fund known as the Certificate of Need Program Fund to be expended for the purposes of this article.

(h) No additional intermediate care facility/skilled nursing facility (ICF/SNF) nursing home beds shall be granted a certificate of need, except for applicants which have filed letters of intent or applications for certificates of need for such facilities prior to the fifteenth day of March, one thousand nine hundred eighty-seven and except in the case of facilities designed to replace existing beds in unsafe or substandard existing facilities.

§16-2D-5a. Health care planning council; state health plan; regional health advisory councils.

(a) The department of health shall be responsible for coordinating and developing the health planning research efforts of the state and for all amendments, revisions and updates of the state health plan referred to herein.

(b) There is hereby created a fifteen member health care planning council, whose purpose is to give input and direction to the health care cost review authority

and to the West Virginia department of health in the state health planning process and annual updates of the state health plan.

(c) The state health plan heretofore approved by the Governor shall remain in effect until replaced or modified as follows: The department of health shall prepare a draft of all amendments to the state health plan and shall transmit the drafts to the council and to the state agency. The state agency may present amendments to the department of health proposal to the council for consideration. The council shall then hold public hearings on each amendment as prepared by the department of health. Following the public hearings, the council may amend the proposal and, if the proposed amendment is approved by a majority of the council, the council shall submit the proposed amendment to the Governor for his approval.

(d) The state health plan shall describe those institutional health services which entail annual operating cost in excess of the expenditure minimum for annual operating costs which are needed to provide for the well-being of persons receiving care within the state. At a mimimum, these shall include acute inpatient (including psychiatric inpatient, obstetrical inpatient, and neonatal inpatient), rehabilitation, and long-term care services. The state health plan shall also describe other health services needed to provide for the well-being of persons receiving care within the state, including, at a minimum, preventive, ambulatory, and home health services and treatment for alcohol and drug abuse. The state health plan shall also describe the number and type of resources, including facilities, personnel, major medical equipment, and other resources required to meet the goal of the plan and shall state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired. Finally, the state health plan shall contain a detailed statement of goals.

(e) The health care planning council shall be composed of the director of the West Virginia department

of health, the commissioner of the West Virginia department of human services, the commissioner of insurance, the chairman of the public employees insurance board, the chairman of the West Virginia health care cost review authority, and the executive director of the commission on aging by virtue of their appointive office; five public members, who shall consist of one representative of senior citizens, one representative of labor, one representative of business, one representative of the health insurance industry, one representative from regional health advisory councils who shall be nominated by the regional health advisory councils; and four representatives of the health care industry, one of whom shall represent physicians, one of whom shall represent registered nurses, one of whom shall represent the long term care industry, and one of whom shall represent hospitals. The members shall be appointed by the governor with the advice and consent of the senate. Appointment of members of the health care planning council shall be made with due diligence to ensure membership thereon by persons representing cultural, demographic and ethnic segments of the population of this state. Lay and professional members of the health care planning council shall be appointed for terms of three years each, except that of those first appointed, three members shall be appointed for terms of one year, three members for terms of two years and three members for terms of three years, and each shall be eligible for reappointment to a subsequent three-year term. Vacancies shall be filled in the same manner as the original appointments for the duration of the unexpired term.

(f) The presence of a majority of the members of the health care planning council shall constitute a quorum for the transaction of business. The health care planning council shall elect a chairman, vice chairman, and such other officers as it shall deem necessary who shall serve at the will and pleasure of the members. The health care planning council shall meet no less than four times during the calendar year, and additional meetings shall be held upon call of the chairman or a majority of the members.

(g) The health care planning council members shall be reimbursed for expenses necessary to carry out their responsibilities and for reasonable travel expenses to attend health care planning council meetings.

(h) The health care cost review authority shall transmit to the department of health such data, records, reports, analyses and summaries filed, collected and developed by the authority as are necessary to health planning functions or related to health planning activities.

(i) In recognition of the importance of local community involvement in health planning and development efforts, each planning and development council region of the state shall have a regional health advisory council which shall meet at least quarterly and shall review health care needs and organize public hearings on the health care issues within the region. Regional health advisory councils shall regularly report to the health care planning council regarding recommendations on health care needs and concerns in their respective regions. Regional health advisory councils shall be provided sufficient staff by the department of health to carry out their responsibility under this article. The department of health shall arrange for an annual meeting of the regional health advisory councils for purposes of exchanging information, continuing education and electing a regional health advisory council representative to serve on the health care planning council. Each regional health advisory council shall consist of members from each county within the region, which members shall be appointed by the respective county commissions. One representative appointed from each county shall be actively involved in health care delivery in the county which such member is appointed, and two representatives from each county within the region shall have no direct affiliation with any health care provider and shall be consumers of health care services. No more than two members appointed from each county may be from the same political party. The presence of a majority of members at regional health advisory council meetings shall constitute a quorum for

purposes of transacting business.

(j) The council shall make its own report to the state agency, the Governor and the Legislature within thirty days of the close of each fiscal year. This report shall include summaries of all meetings of the council and any public comments on decisions, together with any suggestions and policy recommendations. In addition, the council shall make a study of the impact of the moratorium imposed by section five, subsection (h) of this article as to its effects on the long-term care availability and accessibility and report to the Legislature on or before the first day of January, one thousand nine hundred eighty-eight.

(k) In the event that the heath planning function established by this section is not funded through the general revenue fund, the state agency will provide, on an annual basis, through inter-agency transfer to the department of health the sum of two hundred thousand dollars for health planning programs described herein.

(l) The department of health shall promulgate rules and regulations in accordance with chapter twenty-nine-a to further implement the provisions of this section.

§16-2D-7. Procedures for certificate of need reviews.

(a) Prior to submission of an application for a certificate of need, the state agency shall require the submission of long-range plans by health care facilities with respect to the development of proposals subject to review under this article. The plans shall be in such form and contain such information as the state agency shall require.

(b) An application for a certificate of need shall be submitted to the state agency prior to the offering or development of all new institutional services within this state. Persons proposing new institutional health services shall submit letters of intent not less than fifteen days prior to submitting an application. The letters of intent shall be of such detail as specified by the state agency.

(c) The state agency may adopt regulations pursuant

to section eight of this article for:

(1) Provision for applications to be submitted in accordance with a timetable established by the state agency;

(2) Provision for such reviews to be undertaken in a timely fashion; and

(3) Except for proposed new institutional health services which meet the requirements for consideration under subsection (g), section nine of this article with regard to the elimination or prevention of certain imminent safety hazards or to comply with certain licensure or accreditation standards, provision for all completed applications pertaining to similar types of services, facilities or equipment to be considered in relation to each other, at least three times a year.

(d) An application for a certificate of need shall specify the time the applicant will require to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure.

(e) The application shall be in such form and contain such information as the state agency shall establish by rule or regulation, but requests for information shall be limited to only that information which is necessary for the state agency to perform the review.

(f) Within fifteen days of receipt of application, the state agency shall determine if the application is complete. The state agency may request additional information from the applicant.

(g) The state agency shall provide timely written notice to the applicant and to all affected persons of the beginning of the review, and to any person who has asked the state agency to place the person's name on a mailing list maintained by the state agency. Notification shall include the proposed schedule for review, the period within which a public hearing during the course of the review may be requested by affected persons, which period may not be less than thirty days from the date of the written notification of the beginning of the

review required by this section, and the manner in which notification will be provided of the time and place of any public hearing so requested. For the purposes of this subsection, the date of notification is the date on which the notice is sent or the date on which the notice appears in a newspaper of general circulation, whichever is later.

(h) Written notification to members of the public and third-party payers may be provided through newspapers of general circulation in the applicable health service area and public information channels; notification to all other affected persons shall be by mail which may be as part of a newsletter.

(i) If, after a review has begun, the state agency requires the person subject to the review to submit additional information respecting the subject of the review, such person shall be provided at least fifteen days to submit the information and the state agency shall, at the request of such person, extend the review period by fifteen days. This extension applies to all other applications which have been considered in relation to the application for which additional information is required.

(j) The state agency shall adopt schedules for reviews which provide that no review may, to the extent practicable, take longer than ninety days from the date that notification, as described under subsection (g) of this section, is sent to the applicant to the date of the final decision of the state agency, and in the case of expedited applications, may by regulations adopted pursuant to section eight of this article provide for a shortened review period.

(k) The state agency shall adopt criteria for determining when it would not be practicable to complete a review within ninety days.

(l) The state agency shall provide a public hearing in the course of agency review if requested by any affected person and the state agency may on its own initiate such a public hearing.

(1) The state agency shall, prior to such hearing, provide notice of such hearing and shall conduct such hearing in accordance with administrative hearing requirements in article five, chapter twenty-nine-a of this code, and its procedure adopted pursuant to this section.

(2) In a hearing any person has the right to be represented by counsel and to present oral or written arguments and evidence relevant to the matter which is the subject of the hearing. Any person affected by the matter which is the subject of the hearing may conduct reasonable questioning of persons who make factual allegations relevant to such matter.

(3) The state agency shall maintain a verbatim record of the hearing.

(4) After the commencement of a hearing on the applicant's application and before a decision is made with respect to it, there may be no ex parte contacts between (a) the applicant for the certificate of need, any person acting on behalf of the applicant or holder of a certificate of need, or any person opposed to the issuance of a certificate for the applicant and (b) any person in the state agency who exercises any responsibility respecting the application.

(5) The state agency may not impose fees for such a public hearing.

(m) If a public hearing is not conducted during the review of a new institutional health service, the state agency may, by regulations adopted pursuant to section eight of this article, provide for a file closing date during the review period after which date no other factual information or evidence may be considered in the determination of the application for the certificate of need. A detailed itemization of documents in the state agency file on a proposed new institutional health service shall, on request, be made available by the state agency at any time before the file closing date.

(n) The extent of additional information received by the state agency from the applicant for a certificate of

need after a review has begun on the applicant's proposed new institutional health service, with respect to the impact on such new institutional health service and additional information which is received by the state agency from the applicant, may be cause for the state agency to determine the application to be a new proposal, subject to a new review cycle.

(o) The state agency shall in timely fashion notify, upon request, providers of health services and other persons subject to review under this article of the status of the state agency review of new institutional health services subject to review, findings made in the course of such review, and other appropriate information respecting such review.

(p) The state agency shall prepare and publish, at least annually, reports of reviews completed and being conducted, with general statements about the status of each review still in progress and the findings and rationale for each completed review since the publication of the last report.

(q) The state agency shall provide for access by the general public to all applications reviewed by the state agency and to all other pertinent written materials essential to agency review.

(r) (1) Any person may request in writing a public hearing for purposes of reconsideration of a state agency decision. No fees may be imposed by the state agency for the hearing. For purposes of this section, a request for a public hearing for purposes of reconsideration shall be deemed to have shown good cause if, in a detailed statement, it:

(A) Presents significant, relevant information not previously considered by the state agency, and demonstrates that with reasonable diligence the information could not have been presented before the state agency made its decision;

(B) Demonstrates that there have been significant changes in factors or circumstances relied upon by the state agency in reaching its decision;

(C) Demonstrates that the state agency has materially failed to follow its adopted procedures in reaching its decision; or

(D) Provides such other bases for a public hearing as the state agency determines constitutes good cause.

(2) To be effective, a request for such a hearing shall be received within thirty days after the date upon which all parties received notice of the state agency decision, and the hearing shall commence within thirty days of receipt of the request.

(3) Notification of such public hearing shall be sent, prior to the date of the hearing, to the person requesting the hearing, the person proposing the new institutional health service, and shall be sent to others upon request.

(4) The state agency shall hold public reconsideration hearings in accordance with the provisions for administrative hearings contained in:

(A) Its adopted procedures;

(B) Ex parte contact provisions of subdivision (4), subsection (1) of this section; and

(C) The administrative procedures for contested cases contained in article five, chapter twenty-nine-a of this code.

(5) The state agency shall make written findings which state the basis for its decision within forty-five days after the conclusion of such hearing.

(6) A decision of the state agency following a reconsideration hearing shall be considered a decision of the state agency for purposes of sections nine and ten of this article and for purposes of the notification of the status of review, findings and annual report provisions of subsections (o) and (p) of this section.

(s) The state agency may adopt regulations pursuant to section eight of this article for reviews and such regulations may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed.

(t) Notwithstanding other provisions of this article, the state agency shall adopt rules and regulations for determining when there is an application which warrants expedited review. If procedures adopted by the state agency to handle expedited applications do not conform to the provisions of this article, such procedures shall be approved by the federal secretary of health and human services and shall be adopted as regulations pursuant to section eight of this article.

ARTICLE 29B. WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY.

§16-29B-11. Certificate of need program.

The board shall carry out and perform all functions set forth in article two-d of this chapter, including review and approval or disapproval of capital expenditures for health care facilities or services. In making decisions in the certificate of need review process, the board shall be guided by the state health plan approved by the Governor.

§16-29B-19. Rate-setting powers generally.

(a) The board shall have power: (1) To initiate reviews and investigations of hospital rates and establish and approve such rates; (2) to initiate reviews and investigations of hospital rates for specific services and the component factors which determine such rates; (3) to initiate reviews and investigations of hospital budgets and the specific components of such budgets; and (4) to approve or disapprove hospital rates and budgets taking into consideration the criteria set forth in section twenty of this article.

(b) In the interest of promoting the most efficient and effective use of hospital service, the board may adopt and approve alternative methods of rate determination. The board may also adopt methods of charges and payments of an experimental nature which are in the public interest and consistent with the purpose of this article.

§16-29B-20. Rate determination.

(a) Upon commencement of review activities, no rates

may be approved by the board nor payment be made for services provided by hospitals under the jurisdiction of the board by any purchaser or third-party payor to or on behalf of any purchaser or class of purchasers unless:

(1) The costs of the hospital's services are reasonably related to the services provided and the rates are reasonably related to the costs;

(2) The rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or regulations conflict with this requirement. Equity among classes of purchasers may be achieved by considering demonstrated differences in the financial requirements of hospitals resulting from service, coverage and payment characteristics of a class of purchasers. The provision for differentials in rates among classes of purchasers should be carried out in the context of each hospital's total financial requirements for the efficient provision of necessary services. The board shall institute a study of objective methods of computing the percentage differential to be utilized for all hospitals in determining appropriate projected gross revenues under subsection (b) of this section. Such study shall include a review and determination of the relevant and justifiable economic factors which can be considered in setting such differential. The differential shall be allowed for only those activities and programs which result in quantifiable savings to the hospital with respect to patient care costs, bad debts, free care or working capital, or reductions in the payments of other payors. Each component utilized in determining the differential shall be individually quantified so that the differential shall equal the value assigned to each component. The board shall consider such matters as coverage to individual subscribers, the elderly and small groups, payment practices, savings in hospital administrative costs, cost containment programs and working capital. The study shall also provide for a method of annual recomputation of the differential and triennial recomputation of all other components. The board may

contract with any person or entity to assist the board in the discharge of its duties as herein stated. Whoever obstructs any person or entity conducting a study authorized under the provisions of this section shall be deemed to be in violation of this article and shall be subject to any appropriate actions, including injunctive relief, as may be necessary for the enforcement of this section;

(3) The rates of payment for medicaid are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provisions of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality;

(4) The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board;

(5) In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in such hospital's gross revenues for either rate-setting or assessment purposes.

(b) In the interest of promoting efficient and appropriate utilization of hospital services the board shall review and make findings on the appropriateness of projected gross revenues for a hospital as such revenues relate to charges for services and anticipated incidence of service. The board shall further render a decision as to the amount of net revenue over expenditures that is appropriate for the effective operation of the hospital.

(c) When applying the criteria set forth above, the board shall consider all relevant factors including, but not limited to, the following: The economic factors in the hospital's area; the hospital's efforts to share services; the hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the

health status of those served; the efficiency of the hospital as to cost and delivery of health care; the quality of care; occupancy level; a fair return on invested capital, not otherwise compensated for; whether the hospital is operated for profit or not for profit; costs of education; and, income from any investments and assets not associated with patient care, including, but not limited to, parking garages, residences, office buildings, and income from foundations and restricted funds whether or not so associated.

(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article shall not be subject to review unless the board first determines that such wages, salaries and benefits may be unreasonably or uncustomarily high or low. Said exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. "Nonsupervisory personnel," for the purposes of this section, means, but is not limited to, employees of hospitals subject to the provisions of this article who are paid on an hourly basis.

(e) Reimbursement of capital and operating costs for new services and capital projects subject to article two-d of this chapter shall not be allowed by the board if such costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved by the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four, pursuant to the provisions of article two-d of this chapter.

(f) The board shall consult with relevant licensing agencies and may require them to provide written findings with regard to their statutory functions and information obtained by them in the pursuit of those functions. Any licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the board together with any findings.

(g) Rates shall be set by the board in advance of the year during which they apply except for the procedure set forth in subsection (c), section twenty-one of this article and shall not be adjusted for costs actually incurred.

(h) All determinations, orders and decisions of the board with respect to rates and revenues shall be prospective in nature.

(i) No hospital may charge for services at rates in excess of those established in accordance with the requirements of and procedures set forth in this article.

(j) Notwithstanding any other provision of this article, the board shall approve all requests for rate increases by hospitals where the rate of increase in the hospital's gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors is equal to or less than the rate of inflation for the hospital industry nationally as measured by the most recent hospital market basket component of the consumer price index as reported by the United States Bureau of Labor Statistics applicable to the hospital's fiscal year. The board may, by regulation, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted herein.

§16-29B-21. Procedure for obtaining initial rate schedule; adjustments and revisions of rate schedules.

(a) No hospital subject to this article may change or amend its schedule of rates except in accordance with the following procedures:

(1) Any request for a change in rate schedules or other changes must be filed in writing to the board with such supporting data as the hospital seeking to change its rates considers appropriate, in the form prescribed by the board. Upon receipt of notice, the board, if it considers necessary, may hold a public hearing on the proposed change. Such hearing shall be held no later than forty-five days after receipt of the notice. The review of the proposed change may not exceed an overall

period of one hundred eighty days from the date of filing to the date of the board's order. If the board fails to complete its review of the proposed change within the time period specified for the review, the proposed change shall be deemed to have been approved by the board. Any proposed change shall go into effect upon the date specified in the order;

(2) Each hospital shall establish, in a written report which shall be incorporated into each proposed rate application, that it has thoroughly investigated and considered:

(A) The economic and social impact of any proposed rate increase, or service decrease, on hospital cost containment and upon health care purchasers, including classes of purchasers, such as the elderly and low and fixed income persons;

(B) State-of-the-art advances in health care cost containment, hospital management and rate design, as alternatives to or in mitigation of any rate increase, or service decrease, which report shall describe the state-of-the-art advances considered and shall contain specific findings as to each consideration, including the reasons for adoption or rejection of each;

(C) Implementation of cost control systems, including the elimination of unnecessary or duplicative facilities and services, promotion of alternative forms of care, and other cost control mechanisms;

(D) Initiatives to create alternative delivery systems; and

(E) Efforts to encourage third-party payors, including, but not limited to, insurers, health service, care and maintenance organizations, to control costs, including a combination of education, persuasion, financial incentives and disincentives to control costs;

(3) In the event the board modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule, the hospital shall have the right to accept the benefits of the partial increase in rates and charge its purchasers

accordingly without in any way adversely affecting or waiving its right to appeal that portion of the decision and order of the board which denied the remainder of the requested rate increase.

(b) The board shall allow a temporary change in a hospital's rates which may be effective immediately upon filing and in advance of review procedures when a hospital files a verified claim that such temporary rate changes are in the public interest, and are necessary to prevent insolvency, to maintain accreditation or for emergency repairs or to relieve undue financial hardship. The verified claim shall state the facts supporting the hospital's position, the amount of increase in rates required to alleviate the situation, and shall summarize the overall effect of the rate increase. The claim shall be verified by either the chairman of the hospital's governing body or by the chief executive officer of the hospital.

(c) Following receipt of the verified claim for temporary relief, the board shall review the claim through its usual procedures and standards; however, this power of review does not affect the hospital's ability to place the temporary rate increase into effect immediately. The review of the hospital's claim shall be for a permanent rate increase and the board may include such other factual information in the review as may be necessary for a permanent rate increase review. As a result of its findings from the permanent review, the board may allow the temporary rate increase to become permanent, to deny any increase at all, to allow a lesser increase, or to allow a greater increase.

(d) When any change affecting an increase in rates goes into effect before a final order is entered in the proceedings, for whatever reasons, where it deems it necessary and practicable, the board may order the hospital to keep a detailed and accurate account of all amounts received by reason of the increase in rates and the purchasers and third-party payors from whom such amounts were received. At the conclusion of any hearing, appeal or other proceeding, the board may order the hospital to refund with interest to each

affected purchaser and/or third-party payor any part of the increase in rates that may be held to be excessive or unreasonable. In the event a refund is not practicable, the hospital shall, under appropriate terms and conditions determined by the board, charge over and amortize by means of a temporary decrease in rates whatever income is realized from that portion of the increase in rates which was subsequently held to be excessive or unreasonable.

(e) The board, upon a determination that a hospital has overcharged purchasers or charged purchasers at rates not approved by the board or charged rates which were subsequently held to be excessive or unreasonable, may prescribe rebates to purchasers and third-party payors in effect by the aggregate total of the overcharge.

(f) The board may open a proceeding against any hospital at any time with regard to compliance with rates approved and the efficiency and effectiveness of the care being rendered in the hospital.

§16-29B-28. Termination date.

After having conducted a performance and fiscal audit through its joint committee on government operations, pursuant to section nine, article ten, chapter four of this code, the Legislature hereby finds and declares that the health care cost review authority should be continued and reestablished. Accordingly, notwithstanding the provisions of subsection seven of section four, article ten, chapter four of this code, the health care cost review authority shall continue to exist until the first day of July, one thousand nine hundred ninety-one.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Bruce O. Williams
Chairman Senate Committee

Lyle Sattes
Chairman House Committee

Originating in the House.

Takes effect ninety days from passage.

Todd C. Wills
Clerk of the Senate

Donald L. Kopp
Clerk of the House of Delegates

Dan Tonkovich
President of the Senate

Speaker of the House of Delegates

The within approved this the 2nd day of April, 1987.

Arch A. Moore, Jr.
Governor

PRESENTED TO THE
GOVERNOR
Date 5/27/87
Time 3:24 p.m.