HB 2476.

WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1995

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ENROLLED

Com. Sub. for

HOUSE BILL No. 2476

(By Delegates Kiss and Petersen)

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Passed March 10, 1995

In Effect from Passage

ENROLLED

COMMITTEE SUBSTITUTE

FOR

H. B. 2476

(By Delegates Kiss and Petersen)

[Passed March 10, 1995; in effect from passage.]

AN ACT to amend and reenact sections two, three, five and six, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating generally to certificate of need procedures; providing the definition of terms; requiring certificate of need for new providers of personal care services; setting forth minimum review criteria for certificate of need; authorizing the health care cost review authority to amend or modify certificate of need standards; setting forth the requirements for amending the standards; and authorizing the health care cost review authority to declare a limited moratorium for purposes of amending obsolete or nonexistent standards.

Be it enacted by the Legislature of West Virginia:

That sections two, three, five and six, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, 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 payors 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: *Provided, however,* That such exemption from review of private office practice shall not be construed to include certain health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(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: *Provided, however,* That such exemption from review of private office practice shall not be construed to include certain health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(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 subparagraph (i), paragraph (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 paragraph (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 expendi-

tures 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 seven hundred fifty thousand dollars per fiscal year.

(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 paragraph (A), subdivision (2), subsection (k) 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 super-

vision 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 three hundred 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 three hundred 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) "Personal care services" means medically oriented activities or tasks ordered by a physician and which is implemented according to a nursing plan of care which has been completed by, and which is supervised by, a registered nurse and billed to the state. These services include those activities which are intended to enable persons to meet their physical needs and to be treated by a physician in their place of residence. The term shall include, but not be limited to, services related to personal

hygiene, dressing, feeding, nutrition, environmental support functions and health related tasks.

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

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

(y) "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.

(z) "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.

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

(bb) "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.

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

(dd) "State health plan" means the document approved by the governor after preparation by the former health care planning commission, or that document as approved by the governor after amendment by the health care planning council or its successor agency.

(ee) "Substantial change to the bed capacity" of a health care facility means any change, with which a capital expenditure is associated, 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: *Provided*, That a decrease in bed capacity in response to federal rural health initiatives shall be excluded from this definition.

(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-3. Certificate of need.

Except as provided in section four of this article, any new institutional health service may not be acquired, offered or developed within this state except upon application for and receipt of a certificate of need as provided by this article. Any new provider of personal care service offered by any person, facility, corporation or entity, other than an agency of the state, may not be offered or developed in this state, if the service is to be funded in whole, or in part, by state or federal medicaid funds, except upon application for and receipt of a certificate of need as pro-

vided in section six of this article: *Provided,* That a certificate of need shall not be required for a person providing specialized foster care personal care services to one individual and those services are delivered in the provider's home. Whenever a new institutional health service for which a certificate of need is required by this article is proposed for a health care facility for which, pursuant to section four of this article, no certificate of need is or was required, a certificate of need shall be issued before the new institutional health service is offered or developed. No person may knowingly charge or bill for any health services associated with any new institutional health service that is knowingly acquired, offered or developed in violation of this article, and any bill made in violation of this section is legally unenforceable. For purposes of this article, a proposed "new institutional health service" includes:

(a) The construction, development, acquisition or other establishment of a new health care facility or health maintenance organization;

(b) The partial or total closure of a health care facility or health maintenance organization with which a capital expenditure is associated;

(c) Any obligation for a capital expenditure incurred by or on behalf of a health care facility, except as exempted in section four of this article, or health maintenance organization in excess of the expenditure minimum or any obligation for a capital expenditure incurred by any person to acquire a health care facility. An obligation for a capital expenditure is considered to be incurred by or on behalf of a health care facility:

(1) When a contract, enforceable under state law, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset;

(2) When the governing board of the health care facil-

ity takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or

(3) In the case of donated property, on the date on which the gift is completed under state law;

(d) A substantial change to the bed capacity of a health care facility with which a capital expenditure is associated;

(e) (1) The addition of health services which are offered by or on behalf of a health care facility or health maintenance organization and which were not offered on a regular basis by or on behalf of the health care facility or health maintenance organization within the twelve-month period prior to the time the services would be offered; and

(2) The addition of ventilator services for any nursing facility bed by any health care facility or health maintenance organization;

(f) The deletion of one or more health services, previously offered on a regular basis by or on behalf of a health care facility or health maintenance organization which is associated with a capital expenditure;

(g) A substantial change to the bed capacity or health services offered by or on behalf of a health care facility, whether or not the change is associated with a proposed capital expenditure, if the change is associated with a previous capital expenditure for which a certificate of need was issued and if the change will occur within two years after the date the activity which was associated with the previously approved capital expenditure was undertaken;

(h) The acquisition of major medical equipment;

(i) A substantial change in an approved new institutional health service for which a certificate of need is in effect. For purposes of this subsection, "substantial

change" shall be defined by the state agency in regulations adopted pursuant to section eight of this article.

§16-2D-5. Powers and duties of state 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 be responsible for coordinating and developing the health planning research efforts of the state and for amending and modifying the state health plan which includes the certificate of need standards.

(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) 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.

(g) No hospital, nursing home or other health care facility shall add any intermediate care or skilled nursing beds to its current licensed bed complement. This prohibition also applies to the conversion of acute care or other types of beds to intermediate care or skilled nursing beds: *Provided,* That hospitals eligible under the provisions of section four-a and subsection (i), section five of this article may convert acute care beds to skilled nursing beds in accordance with the provisions of these sections, upon approval by the state agency. Furthermore, no certificate of need shall be granted for the construction or addition of any intermediate care or skilled nursing beds except in the case of facilities designed to replace existing beds in unsafe existing facilities. A health care facility in receipt of a certificate of need for the construction or addition of intermediate care or skilled nursing beds which was approved prior to the effective date of this section must incur an obligation for a capital expenditure within twelve months of the date of issuance of the certificate of need. No extensions shall be granted beyond the twelve-month period: *Provided, however,* That a maximum of sixty beds may be approved, as a demonstration project, by the state agency for a unit to provide nursing services to patients with alzheimer's disease if: (1) The unit is located in an existing facility which was formerly owned and operated by the state of West Virginia and is presently owned by a county of the state of West Virginia; (2) the facility has provided health care services, including personal care services, within one year prior to the effective date of this section; (3) the facility demonstrates that awarding the certificate of need and operating the facility will be cost

effective for the state; and (4) that any applicable lease, lease-purchase or contract for operating the facility was awarded through a process of competitive bidding consistent with state purchasing practices and procedures: *Provided further*, That an application for said demonstration project shall be filed with the state agency on or before the twenty-first day of October, one thousand nine hundred ninety-three.

(h) No additional intermediate care facility for the mentally retarded (ICF/MR) beds shall be granted a certificate of need, except that prohibition does not apply to ICF/MR beds approved under the Kanawha County circuit court order of the third day of August, one thousand nine hundred eighty-nine, civil action number MISC-81-585 issued in the case of *E. H. v. Matin*, 168 W.V. 248, 284 S.E.2d 232 (1981).

(i) Notwithstanding the provisions of subsection (g), section five of this article and, further notwithstanding the provisions of subsection (d), section three of this article, an existing acute care hospital may apply to the health care cost review authority for a certificate of need to convert acute care beds to skilled nursing beds: *Provided*, That the proposed skilled nursing beds are medicare certified only: *Provided, however,* That any hospital which converts acute care beds to medicare certified only skilled nursing beds is prohibited from billing for any medicaid reimbursement for any beds so converted. In converting beds, the hospital must convert a minimum of one acute care bed into one medicare certified only skilled nursing bed. The health care cost review authority may require a hospital to convert up to and including three acute care beds for each medicare certified only skilled nursing bed. The health care cost review authority shall adopt rules to implement this subsection which require that:

(1) All acute care beds converted shall be permanently deleted from the hospital's acute care bed complement and the hospital may not thereafter add, by conversion or

otherwise, acute care beds to its bed complement without satisfying the requirements of subsection (d), section three of this article for which purposes such an addition, whether by conversion or otherwise, shall be considered a substantial change to the bed capacity of the hospital notwithstanding the definition of that term found in subsection (ee), section two of this article.

(2) The hospital shall meet all federal and state licensing certification and operational requirements applicable to nursing homes including a requirement that all skilled care beds created under this subsection shall be located in distinct-part, long-term care units.

(3) The hospital must demonstrate a need for the project.

(4) The hospital must use existing space for the medicare certified only skilled nursing beds. Under no circumstances shall the hospital construct, lease or acquire additional space for purposes of this section.

(5) The hospital must notify the acute care patient, prior to discharge, of facilities with skilled nursing beds which are located in or near the patient's county of residence.

Nothing in this subsection shall negatively affect the rights of inspection and certification which are otherwise required by federal law or regulations or by this code of duly adopted regulations of an authorized state entity.

(j) Notwithstanding the provisions of subsection (g) of this section, a retirement life care center with no skilled nursing beds may apply to the health care cost review authority for a certificate of need for up to sixty skilled nursing beds provided the proposed skilled beds are medicare certified only. On a statewide basis, a maximum of one hundred eighty skilled beds which are medicare certified only may be developed pursuant to this subsection. The state health plan shall not be applicable to projects

submitted under this subsection. The health care cost review authority shall adopt rules to implement this subsection which shall include:

(1) A requirement that the one hundred eighty beds are to be distributed on a statewide basis;

(2) There shall be a minimum of twenty beds and a maximum of sixty beds in each approved unit;

(3) The unit developed by the retirement life care center shall meet all federal and state licensing certification and operational requirements applicable to nursing homes;

(4) The retirement center must demonstrate a need for the project;

(5) The retirement center must offer personal care, home health services and other lower levels of care to its residents; and

(6) The retirement center must demonstrate both short and long-term financial feasibility.

Nothing in this subsection shall negatively affect the rights of inspection and certification which are otherwise required by federal law or regulations or by this code of duly adopted regulations of an authorized state entity.

(k) The provisions of this article are severable and if any provision, section or part thereby shall be held invalid, unconstitutional or inapplicable to any person or circumstance, such invalidity, unconstitutionality or inapplicability shall not affect or impair any other remaining provisions contained herein.

(l) The state agency is hereby empowered to order a moratorium upon the processing of an application or applications for the development of a new institutional health service filed pursuant to section three of this article, when criteria and guidelines for evaluating the need for

such new institutional health service have not yet been adopted or are obsolete. Such moratorium 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 institutional health service affected by the moratorium, or one hundred eighty 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.

(m) The state agency shall coordinate the collection of information needed to allow the state agency to develop recommended modifications to certificate of need standards as required in this article. When the state agency proposes amendments or modifications to the certificate of need standards, they shall file with the secretary of state, for publication in the state register, a notice of proposed action, including the text of all proposed amendments and modifications, and a date, time and place for receipt of general public comment. To comply with the public comment requirement of this section, the state agency may hold a public hearing or schedule a public comment period for the receipt of written statements or documents.

All proposed amendments and modifications to the certificate of need standards, with a record of the public hearing or written statements and documents received pursuant to a public comment period, shall be presented to the governor. Within thirty days of receiving said proposed amendments or modifications, the governor shall either approve or disapprove all or part of said amendments and modifications, and, for any portion of amendments or modifications not approved, shall specify the reason or reasons for nonapproval. Any portions of the amendments or modifications not approved by the governor may be revised and resubmitted.

§16-2D-6. Minimum criteria for certificate of need reviews.

(a) Except as provided in subsections (f) and (g), section nine of this article, in making its determination as to whether a certificate of need shall be issued, the state agency shall, at a minimum, consider all of the following criteria that are applicable: *Provided,* That in the case of a health maintenance organization or an ambulatory care facility or health care facility controlled, directly or indirectly, by a health maintenance organization or combination of health maintenance organizations, the criteria considered shall be only those set forth in subdivision (12) of this subsection: *Provided, however,* That the criteria set forth in subsection (f) of this section applies to all hospitals, nursing homes and health care facilities when ventilator services are to be provided for any nursing facility bed:

(1) The recommendation of the designated health systems agency for the health service area in which the proposed new institutional health service is to be located;

(2) The relationship of the health services being reviewed to the state health plan and to the applicable health systems plan and annual implementation plan adopted by the designated health systems agency for the health service area in which the proposed new institutional health service is to be located;

(3) The relationship of services reviewed to the long-range development plan of the person providing or proposing the services;

(4) The need that the population served or to be served by the services has for the services proposed to be offered or expanded, and the extent to which all residents of the area, and in particular low income persons, racial and ethnic minorities, women, handicapped persons, other medically underserved population, and the elderly, are likely to have access to those services;

(5) The availability of less costly or more effective alternative methods of providing the services to be offered,

expanded, reduced, relocated or eliminated;

(6) The immediate and long-term financial feasibility of the proposal as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health service;

(7) The relationship of the services proposed to the existing health care system of the area in which the services are proposed to be provided;

(8) In the case of health services proposed to be provided, the availability of resources, including health care providers, management personnel, and funds for capital and operating needs, for the provision of the services proposed to be provided and the need for alternative uses of these resources as identified by the state health plan, applicable health systems plan and annual implementation plan;

(9) The appropriate and nondiscriminatory utilization of existing and available health care providers;

(10) The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services;

(11) Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. The entities may include medical and other health professional schools, multidisciplinary clinics and specialty centers;

(12) To the extent not precluded by subdivision (1), subsection (f), section nine of this article, the special needs and circumstances of health maintenance organizations. These needs and circumstances are limited to:

(A) The needs of enrolled members and reasonably

anticipated new members of the health maintenance organization for the health services proposed to be provided by the organization; and

(B) The availability of the new health services from nonhealth maintenance organization providers or other health maintenance organizations in a reasonable and cost-effective manner which is consistent with the basic method of operation of the health maintenance organization. In assessing the availability of these health services from these providers, the agency shall consider only whether the services from these providers:

(i) Would be available under a contract of at least five years' duration;

(ii) Would be available and conveniently accessible through physicians and other health professionals associated with the health maintenance organization;

(iii) Would cost no more than if the services were provided by the health maintenance organization; and

(iv) Would be available in a manner which is administratively feasible to the health maintenance organization;

(13) The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages;

(14) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the need that the population presently served has for the service, the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, other medically underserved population, and the elderly, to obtain needed health care;

(15) In the case of a construction project: (A) The cost and methods of the proposed construction, including the costs and methods of energy provision and (B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing the construction project and on the costs and charges to the public of providing health services by other persons;

(16) In the case of health services proposed to be provided, the effect of the means proposed for the delivery of proposed health services on the clinical needs of health professional training programs in the area in which the services are to be provided;

(17) In the case of health services proposed to be provided, if the services are to be available in a limited number of facilities, the extent to which the schools in the area for health professions will have access to the services for training purposes;

(18) In the case of health services proposed to be provided, the extent to which the proposed services will be accessible to all the residents of the area to be served by the services;

(19) In accordance with section five of this article, the factors influencing the effect of competition on the supply of the health services being reviewed;

(20) Improvements or innovations in the financing and delivery of health services which foster competition, in accordance with section five of this article, and serve to promote quality assurance and cost effectiveness;

(21) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed;

(22) In the case of existing services or facilities, the quality of care provided by the services or facilities in the

past;

(23) In the case where an application is made by an osteopathic or allopathic facility for a certificate of need to construct, expand, or modernize a health care facility, acquire major medical equipment, or add services, the need for that construction, expansion, modernization, acquisition of equipment, or addition of services shall be considered on the basis of the need for and the availability in the community of services and facilities for osteopathic and allopathic physicians and their patients. The state agency shall consider the application in terms of its impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels;

(24) The special circumstances of health care facilities with respect to the need for conserving energy;

(25) The contribution of the proposed service in meeting the health related needs of members of medically underserved populations which have traditionally experienced difficulties in obtaining equal access to health services, particularly those needs identified in the state health plan, applicable health systems plan and annual implementation plan, as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the state agency shall consider:

(A) The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved, and the extent to which medically underserved populations are expected to use the proposed services if approved;

(B) The performance of the applicant in meeting its obligation, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance, includ-

ing the existence of any civil rights access complaints against the applicant;

(C) The extent to which medicare, medicaid and medically indigent patients are served by the applicant; and

(D) The extent to which the applicant offers a range of means by which a person will have access to its services, including, but not limited to, outpatient services, admission by a house staff and admission by personal physician;

(26) The existence of a mechanism for soliciting consumer input into the health care facility's decision making process.

(b) The state agency may include additional criteria which it prescribes by regulations adopted pursuant to section eight of this article.

(c) Criteria for reviews may vary according to the purpose for which a particular review is being conducted or the types of health services being reviewed.

(d) An application for a certificate of need may not be made subject to any criterion not contained in this article or not contained in regulations adopted pursuant to section eight of this article.

(e) In the case of any proposed new institutional health service, the state agency may not grant a certificate of need under its certificate of need program unless, after consideration of the appropriateness of the use of existing facilities providing services similar to those being proposed, the state agency makes, in addition to findings required in section nine of this article, each of the following findings in writing: (1) That superior alternatives to the services in terms of cost, efficiency and appropriateness do not exist and the development of alternatives is not practicable; (2) that existing facilities providing services similar to those proposed are being used in an appropriate and efficient manner; (3) that in the case of new construction, alternatives to new construction, such as moderniza-

tion or sharing arrangements, have been considered and have been implemented to the maximum extent practicable; (4) that patients will experience serious problems in obtaining care of the type proposed in the absence of the proposed new service; and (5) that in the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, the addition will be consistent with the plans of other agencies of the state responsible for the provision and financing of long-term care facilities or services including home health services.

(f) In the case where an application is made by a hospital, nursing home or other health care facility to provide ventilator services which have not previously been provided for a nursing facility bed, the state agency shall consider the application in terms of the need for the service and whether the cost exceeds the level of current medicaid services. No facility may, by providing ventilator services, provide a higher level of service for a nursing facility bed without demonstrating that the change in level of service by provision of the additional ventilator services will result in no additional fiscal burden to the state.

(g) In the case where application is made by any person or entity to provide personal care services which are to be billed for medicaid reimbursement, the state agency shall consider the application in terms of the need for the service and whether the cost exceeds the level of the cost of current medicaid services. No person or entity may provide personal care services to be billed for medicaid reimbursement without demonstrating that the provision of the personal care service will result in no additional fiscal burden to the state: *Provided,* That a certificate of need shall not be required for a person providing specialized foster care personal care services to one individual and those services are delivered in the provider's home. The state agency will also consider the total fiscal liability to the state for all applications which have been submitted.

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

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within _____ this the _____

day of _____, 1995.

Governor

PRESENTED TO THE
GOVERNOR
Date 3/31/95
Time 2:32