WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1999

ENROLLED

SENATE BILL NO. 492

(By Senators Tomblin, Mr. President, and
Sprague, by request of the Executive)

PASSED March 13, 1999
In Effect Ninety Days from Passage
AN ACT to amend and reenact sections two, three, four, four-a, five, six, seven, seven-a, eight, nine, ten, eleven, thirteen and fifteen, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, all relating to definitions; certificate of need; new institutional health services definition; exemptions from certificate of need; conversion of acute beds to skilled nursing beds in rural areas; powers and duties of health care authority relating to certificate of need program, health planning, state health plan, application fees, long term care beds, ICF/MR beds, life care retirement centers, moratoriums for certain health services, certificate of need standards and rural health facilities; providing for the conversion of acute care beds to skilled nursing beds at certain hospitals under specified conditions; minimum criteria for certificate of need reviews, long-range plans; procedures for certificate of need reviews; notification to the public; public hearings; file closing;
annual report; access for the public; reconsideration; expedited review; review for nonhealth-related projects; filing with consumer advocate; rule-making powers; final decision; required findings; emergency certificate of need; appeal of final decision; certificate of need is nontransferable; extensions and withdrawals of certificates of need; injunctive relief; civil penalties; and previously approved rules and regulations.

Be it enacted by the Legislature of West Virginia:

That sections two, three, four, four-a, five, six, seven, seven-a, eight, nine, ten, eleven, thirteen and fifteen, 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.

1 Definitions of words and terms defined in articles five-f and twenty-nine-b of this chapter are incorporated in this section unless this section has different definitions.

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

3 (a) “Affected person” means:

4 (1) The applicant;

5 (2) An agency or organization representing consumers;

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

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

8 (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;

9 (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 that establishes rates for health care facilities similar to those proposed; or

(9) Organizations representing health care providers.

(b) "Ambulatory health care facility" means a free-standing facility that provides health care to noninstitutionalized and nonhomebound persons on an outpatient basis. For purposes of this definition, a free-standing facility is not located on the campus of an existing health care facility. 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 this exemption from review shall not be construed to include practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: Provided, however, That this exemption from review 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 free-standing facility that provides surgical treatment to patients not requiring hospitalization. For purposes of this definition, a free-standing facility is not physically attached to a health care facility. 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 this exemption from review shall not be construed to include practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: Provided, however, That this exemption from review shall not be construed to include 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 the 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 licensed to a health care facility, or the number of adult and pediatric beds permanently staffed and maintained for immediate use by inpatients in patient rooms or wards in an unlicensed facility.

(f) "Campus" means the adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health care facility.

(g) "Capital expenditure" means:

(1) An expenditure made by or on behalf of a health care facility, which:

(A)(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)(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;

(2) The donation of equipment or facilities to a health care facility, which if acquired directly by that facility would be subject to review;
(3) The transfer of equipment or facilities for less than fair market value if the transfer of the equipment or facilities at fair market value would be subject to review; or

(4) A series of expenditures, if the sum total exceeds the expenditure minimum and if determined by the state agency to be a single capital expenditure subject to review. In making this 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.

(h) "Expenditure minimum" means two million dollars and includes 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.

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

(j) "Health care facility" means a publicly or privately owned facility, agency or entity that offers or provides health care services, whether a for-profit or nonprofit entity and whether or not licensed, or required to be licensed, in whole or in part, and includes, but is not limited to, 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; hospice agencies; rehabilitation facilities; health maintenance organizations; and community mental health and mental retardation facilities. For purposes of this definition, "community mental health and mental retardation facility" means a private facility which provides such comprehensive services and continuity of
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133 care as emergency, outpatient, partial hospitalization,
134 inpatient or consultation and education for individuals
135 with mental illness, mental retardation or drug or alcohol
136 addiction.

137 (k) "Health care provider" means a person, partnership,
138 corporation, facility, hospital or institution licensed or
139 certified or authorized by law to provide professional
140 health care service in this state to an individual during
141 that individual's medical, remedial or behavioral health
142 care, treatment or confinement.

143 (l) "Health maintenance organization" means a public or
144 private organization which:

145 (1) Is required to have a certificate of authority to
146 operate in this state pursuant to section three, article
147 twenty-five-a, chapter thirty-three of this code; or

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

153 (B) Is compensated except for copayments for the
154 provision of the basic health care services listed in para-
155 graph (A) of this subdivision to enrolled participants on a
156 predetermined periodic rate basis without regard to the
157 date the health care services are provided and which is
158 fixed without regard to the frequency, extent or kind of
159 health service actually provided; and

160 (C) Provides physicians' services: (i) Directly through
161 physicians who are either employees or partners of the
162 organization; or (ii) through arrangements with individual
163 physicians or one or more groups of physicians organized
164 on a group practice or individual practice basis.

165 (m) "Health services" means clinically related preven-
166 tive, diagnostic, treatment or rehabilitative services,
167 including alcohol, drug abuse and mental health services.

168 (n) "Home health agency" means an organization
169 primarily engaged in providing professional nursing
services either directly or through contract arrangements
and at least one of the following services: Home health
aide services, other therapeutic services, physical therapy,
speech therapy, occupational therapy, nutritional services
or medical social services to persons in their place of
residence on a part-time or intermittent basis.

(o) “Hospice agency” means a private or public agency
or organization licensed in West Virginia for the adminis-
tration or provision of hospice care services to terminally
ill persons in the persons' temporary or permanent resi-
dences by using an interdisciplinary team, including, at a
minimum, persons qualified to perform nursing services;
social work services; the general practice of medicine or
osteopathy; and pastoral or spiritual counseling.

(p) “Hospital” means a facility licensed as such pursuant
to the provisions of article five-b of this chapter, and any
acute care facility operated by the state government, that
primarily provides inpatient diagnostic, treatment or
rehabilitative services to injured, disabled or sick persons
under the supervision of physicians and includes psychia-
tric and tuberculosis hospitals.

(q) “Intermediate care facility” means an institution that
provides health-related services to individuals with mental
or physical conditions that require services above the level
of room and board, but do not require the degree of
services provided in a hospital or skilled-nursing facility.

(r) “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, which contains the
information required by the state agency in rules adopted
pursuant to section eight of this article.

(s) “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 costs in excess of
two million dollars. This term does not include medical
equipment acquired by or on behalf of a clinical labora-
tory to provide clinical laboratory services if the clinical
a 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 U.S.C. §1395x. In determining whether medical equipment is major medical equipment, 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.

(t) "Medically underserved population" means the population of an area designated by the state agency as having a shortage of personal health services. The state agency may consider unusual local conditions that are a barrier to accessibility or availability of health services. The designation shall be in rules 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 U.S.C. §254.

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

(v) "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 to provide specified health services.

(w) "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.

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

(y) "Proposed new institutional health service" means any service as described in section three of this article.
(z) "Psychiatric hospital" means an institution that 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.

(aa) "Rehabilitation facility" means an inpatient facility 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.

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

(cc) "Skilled nursing facility" means an institution, or a distinct part of an institution, that primarily provides inpatient skilled nursing care and related services, or rehabilitation services, to injured, disabled or sick persons.

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

(ee) "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 former health planning council or the state agency.

(ff) "Substantial change to the bed capacity" of a health care facility means any change, associated with a capital expenditure, 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 excluded from this definition.

(gg) "Substantial change to the health services" of a health care facility means: (1) The addition of a health service offered by or on behalf of the health care facility, 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; (2) or the termination of a health service offered by or on behalf of the facility:

Provided, That “substantial change to the health services” does not include the providing of ambulance service, wellness centers or programs, adult day care or respite care by acute care facilities.

(hh) “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; new institutional health services defined.

(a) 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. 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.

(b) For purposes of this article, a proposed “new institutional health service” includes:

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

(2) The partial or total closure of a health care facility or health maintenance organization with which a capital expenditure is associated;
(3) 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;

(A) 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;

(B) When the governing board of the health care facility
takes formal action to commit its own funds for a con-
struction project undertaken by the health care facility as
its own contractor; or

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

(4) A substantial change to the bed capacity of a health
care facility with which a capital expenditure is associ-
ated;

(5) The addition of health services as specified by the
state agency 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 organi-
zation within the twelve-month period prior to the time
the services would be offered. The state agency shall
promulgate emergency rules pursuant to the provisions of
section fifteen, article three, chapter twenty-nine-a of this
code by the first day of July, one thousand nine hundred
ninety-nine, to specify the health services which are
subject to certificate of need review. The state agency
shall specify by rule those health services subject to
certificate of need as recommended by the certificate of
need study conducted pursuant to section nineteen-a,
article twenty-nine-b of this chapter.
(6) The addition of ventilator services for any nursing facility bed by any health care facility or health maintenance organization;

(7) 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;

(8) 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;

(9) The acquisition of major medical equipment;

(10) 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 rules adopted pursuant to section eight of this article; or

(11) An expansion of the service area for hospice or home health service, regardless of the time period in which the expansion is contemplated or made.

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

(a) Except as provided in subsection (b), subdivision (9), section three of this article, nothing in this article or the rules and rules adopted pursuant to the provisions of this article may be construed to authorize the licensure, supervision, regulation or control in any manner of the following:

(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: Provided, however, That such exemption from review of private office practice shall not be construed to include the acquisition, offering or development of one or more health services, including ambulatory surgical facilities or centers, lithotripsy, magnetic resonance imaging and radiation therapy by one or more health professionals. The state agency shall adopt rules pursuant to section eight of this article which specify the health services acquired, offered or developed by health professionals which are subject to certificate of need review;

(2) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees: Provided, 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 boarding-houses, which provide medical, nursing personnel and health related services;

(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;

(5) The creation of new primary care services located in communities that are underserved with respect to primary care services: Provided, That to qualify for this exemption, an applicant must be a community-based nonprofit organization with a community board that provides or will provide primary care services to people without regard to ability to pay: Provided, however, That the exemption from certificate of need review of new primary care services provided by this subdivision shall not include the acquisition, offering or development of major medical equipment otherwise subject to review under the provisions of this article or to include the acquisition, offering or development of ambulatory surgical facilities, lithotripsy, magnetic resonance imaging or radiation
therapy. The office of community and rural health services shall define which services constitute primary care services for purposes of this subdivision, and shall, to prevent duplication of primary care services, determine whether a community is underserved with respect to certain primary care services within the meaning of this subdivision. Any organization planning to qualify for an exemption pursuant to this subdivision shall submit to the state agency a letter of intent describing the proposed new services and area of service; and

(6) The creation of birthing centers by nonprofit primary care centers that have a community board and provide primary care services to people in their community without regard to ability to pay, or by nonprofit hospitals with less than one hundred licensed acute care beds: Provided, That to qualify for this exemption, an applicant shall be located in an area that is underserved with respect to low-risk obstetrical services: Provided, however, That if a primary care center attempting to qualify for this exemption is located in the same county as a hospital that is also eligible for this exemption, or if a hospital attempting to qualify for this exemption is located in the same county as a primary care center that is also eligible for this exemption, then at least one primary care center and at least one hospital from said county shall collaborate for the provision of services at a birthing center in order to qualify for this exemption: Provided further, That for purposes of this subsection, a “birthing center” is a short-stay ambulatory health care facility designed for low-risk births following normal uncomplicated pregnancy. Any primary care center or hospital planning to qualify for an exemption pursuant to this subdivision shall submit to the state agency a letter of intent describing the proposed birthing center and area of service.

(b) (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) of this subsection, 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) of this subsection, 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 paragraphs (A), (B) and (C) of said subdivision 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.

(c) (1) The state agency may adopt rules 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 is 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) of this subsection 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) of this subsection, 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.

(d) The state agency shall adopt rules 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 existing technology that can reasonably be mobile. The state agency shall specify the types of items in the rules and under what circumstances mobile MRI and mobile lithotripsy may be so exempted from review. In no case, however, will mobile cardiac catheterization be exempted from certificate of need review. In addition, if the shared services mobile unit proves less cost effective than a fixed unit, the acute care facility will not be exempted from certificate of need review.

On a yearly basis, the state agency shall review existing technologies to determine if other shared services should be included under this exemption.
§16-2D-4a. Conversion of hospital acute beds to skilled nursing beds.

(a) Legislative findings and purpose. — The Legislature hereby finds and declares that a need exists for skilled nursing health care beds in this state due to a shortage of existing facilities with adequate bed capacity and lack of willingness to provide such services; that patients in need of skilled nursing services have sometimes been retained in an inappropriate level of care facility; that such practices have resulted in malutilization of health care facilities and resources; that there currently exists a surplus of acute care beds in hospitals, particularly those in rural areas within this state; that the surplus of acute care beds is, for the foreseeable future, permanent in nature; that the same excess capacity of acute care beds promotes economic inefficiencies in operation while failing to meet community needs; that nursing homes are unable under subsection (h), section five of this article, to add intermediate or dually certified beds to skilled nursing beds at the present time in numbers in excess of ten percent or not more than ten beds, whichever is less; and that remedial action by the Legislature is necessary to effectuate relief of these problems to promote the health and welfare of the citizens of the state by allowing, in certain instances, for the conversion of acute care beds to skilled nursing beds by hospitals, but with no increase in overall hospital bed capacity.

(b) Notwithstanding the provisions of subsection (h), section five of this article, and, further, notwithstanding the provisions of subsection (b), subdivision (4), section three of this article, the state agency shall adopt rules pursuant to section eight of this article, to exempt from review the conversion of acute care beds to skilled nursing care beds by a licensed hospital by the state department of health and human resources if the hospital meets the following conditions:

(1) It is located in a nonmetropolitan statistical area as defined by the bureau of census of the federal government;
(2) It has experienced an average occupancy rate of less than fifty percent for the twelve months preceding the date of request for this exemption; and

(3) The nursing home service area within which the hospital is located is under the bed ceiling as calculated by the thirty beds per thousand population formula as set forth in the long-term care chapter of the state health plan, except for the purposes of this article existing nursing home beds shall be used in the calculation.

(c) The state agency shall include in its rules requirements that:

(1) In converting beds, the hospital must change one acute care bed into one skilled nursing care bed;

(2) 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 (b), subdivision (4), 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 (ff), section two of this article;

(3) The hospital shall meet all applicable federal and state licensing requirements for the provisions of skilled nursing services including a requirement that all skilled care beds created under this exemption shall be located in distinct-part, long-term care units;

(4) No hospital is permitted to convert more than twenty-five percent of its licensed bed capacity in any twenty-four month period pursuant to this exemption; however, in the event that subsection (g), section five of this article, is repealed and to the extent that other methods of converting acute care beds are available under this article, the hospital may request certificate of need approval of such conversions;

(5) The hospital shall undergo substantial compliance review of a conversion under this exemption under such
terms and at such a time as set by the state agency in its rules.

(d) Nothing in this section negatively affects the rights of inspection and certification which are elsewhere required by federal law or regulations or by this code or duly adopted ruleof an authorized state entity.

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

(a) The state agency shall administer the certificate of need program as provided by this article.

(b) The state agency is 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. The state agency shall review the state health plan, including the certificate of need standards and make any necessary amendments and modifications within three years from the effective date of this section. The state agency shall also review the cost effectiveness of the certificate of need program. The state agency may form task forces to assist it in addressing these issues. The task forces shall be composed of representatives of consumers, business, providers, payers and state agencies.

(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 the 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
(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 shall 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. The state agency shall establish a task force or utilize an existing task force to study the need for additional nursing facility beds in this state. The study shall include a review of the current moratorium on the development of nursing facility beds; the exemption for the conversion of acute care beds to skilled nursing facility
beds; the development of a methodology to assess the need for additional nursing facility beds; and, certification of new beds both by medicare and medicaid. The task force shall be composed of representatives of consumers, business, providers, payers and government agencies.

(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 (b), section three of this article, an existing acute care hospital may apply to the health care 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 shall not bill for any medicaid reimbursement for any converted beds. In converting beds, the hospital shall convert a minimum of one acute care bed into one medicare certified only skilled nursing bed. The health care authority may require a hospital to convert up to and including three acute care beds for each medicare certified only skilled nursing bed: Provided further, That a hospital designated or provisionally designated by the state agency as a rural primary care hospital may convert up to thirty beds to a distinct-part nursing facility, including skilled nursing beds and intermediate care beds, on a one-for-one basis if the rural primary care hospital is located in a county without a certified free-standing nursing facility and the hospital may bill for medicaid reimbursement for the converted beds: And provided further, That if the hospital rejects the designation as a rural primary care hospital then the hospital may not bill for medicaid reimbursement. The health care 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 (b), section three of this article for which purposes 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 (ff), 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 shall demonstrate a need for the project.

(4) The hospital shall 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 shall 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 negatively affects the rights of inspection and certification which are otherwise required by federal law or regulations or by this code or duly adopted rules of an authorized state entity.

(j) (1) 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 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 is not applicable to projects submitted under this subsection. The health care authority shall adopt rules to implement this subsection which shall include a requirement that:
(A) The one hundred eighty beds are to be distributed on a statewide basis;

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

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

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

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

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

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

(k) The state agency may order a moratorium upon the offering or development of a new institutional health service, when criteria and guidelines for evaluating the need for the new institutional health service have not yet been adopted or are obsolete. The state agency may also order a moratorium on the offering or development of a health service, notwithstanding the provisions of subdivision (5), subsection (b), section three of this article, when it determines that the proliferation of the service may cause an adverse impact on the cost of health care or the health status of the public. A 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 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 applications for certificates of need are processed pursuant to section six of this article.
(l) (1) 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, it 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.

(2) 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 the proposed amendments or modifications, the governor shall either approve or disapprove all or part of the 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.

(m) The state agency may exempt from or expedite rate review, certificate of need, and annual assessment requirements and issue grants and loans to financially vulnerable health care facilities located in underserved areas that the state agency and the office of community and rural health services determine are collaborating with other providers in the service area to provide cost effective health care services.

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

(a) Except as provided in subsection (f), 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 the criteria set forth in subsection (f) of this section apply to all hospitals, nursing
homes and health care facilities when ventilator services are to be provided for any nursing facility bed:

(1) The relationship of the health services being reviewed to the state health plan;

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

(3) 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;

(4) The availability of less costly or more effective alternative methods of providing the services to be offered, expanded, reduced, relocated or eliminated;

(5) 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;

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

(7) 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 and other applicable plans;

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

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

(11) 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;

(12) 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;

(13) 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;

(14) 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;

(15) 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;
(16) In accordance with section five of this article, the factors influencing the effect of competition on the supply of the health services being reviewed;

(17) 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;

(18) 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;

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

(20) 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;

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

(22) 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 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, including 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 housestaff and admission by personal physician;

(23) 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 rules 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 rules 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 pro-
posed, 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 modernization 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 is not 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 shall also consider the total fiscal liability to the state for all applications which have been submitted.

§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 requires.

(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 rules 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 (f), 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 establishes by rule, 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.
(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 rules 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 rules 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 considered 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 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 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 (l) 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 reconsider-
atation 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 rules pursuant to section
eight of this article for reviews and such rules 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 for determining when there
is an application which warrants expedited review.

(u) Notwithstanding other provisions of this article, the
state agency shall promulgate emergency rules pursuant
to the provisions of section fifteen, article three, chapter
twenty-nine-a of this code by the first day of July, one
thousand nine hundred ninety-nine, to establish a review
process for nonhealth related projects. The review process
shall not exceed forty-five days. The state agency shall
specify in the rule which projects are eligible for this
review.

§16-2D-7a. Coordination and filing with consumer advocate.

1  Each health care facility or health care provider filing a
2  certificate of need application with the state agency
3  pursuant to sections four and seven of this article shall
4  notify the director of the office of consumer advocacy
5  established pursuant to section sixteen, article two,
chapter thirty-three of this code of said application by submitting a copy of the same to the office of the consumer advocate on or before the date of such filing.

§16-2D-8. Agency to promulgate additional rules.

(a) The state agency may promulgate additional rules:

(1) To carry out the provisions of this article; and

(2) To assure hospitals' compliance with requests for information concerning rates charged for each of the twenty-five most frequently used hospital services in the State including the average semiprivate and private room rates.

(b) All rules shall be promulgated pursuant to chapter twenty-nine-a of this code and as described herein. In addition, before adopting proposed rules the state agency shall give interested persons an opportunity to offer written comments on the rules, or any revisions thereof, which it proposes to adopt.

(c) Subsequent amendments and modifications to any rule promulgated pursuant to this article may be implemented by emergency rule.

§16-2D-9. Agency to render final decision; issue certificate of need; write findings; specify capital expenditure maximum.

(a) Only the state agency, or the appropriate administrative or judicial review body, may issue, deny or withdraw certificates of need, grant exemptions from certificate of need reviews, or determine that certificate of need reviews are not required.

(b) A certificate of need may only be issued if the proposed new institutional health service is:

(1) Found to be needed; and

(2) Except in emergency circumstances that pose a threat to public health, consistent with the state health plan.

(c) The state agency shall render a final decision on every application for a certificate of need or application for
exemption in the form of an approval, a denial, or an
approval with conditions. Any decision of the state agency
with respect to a certificate of need, or exemption, shall be
based solely on:

(1) The review of the state agency conducted in accor-
dance with procedures and criteria in this article and in
rules adopted pursuant to section eight of this article; and

(2) The record established in administrative proceedings
held with respect to the certificate of need or exemption.

(d) Approval with conditions does not give the state
agency authority to mandate new institutional health
services not proposed by the health care facility or health
maintenance organization. Issuance of a certificate of
need or exemption may not be made subject to any condi-
tion unless the condition directly relates to criteria in this
article or in rules adopted pursuant to section eight of this
article. Conditions may be imposed upon the operations of
the health care facility or health maintenance organization
for no longer than a three-year period. Compliance with
such conditions may be enforced through the mechanisms
detailed in section thirteen of this article.

(e) (1) For each proposed new institutional health service
it approves, the state agency shall, in addition to the
written findings required in subsection (e), section six of
this article, make a written finding, which shall take into
account the current accessibility of the facility as a whole,
on the extent to which the new institutional health service
will meet the criteria in subdivisions (3), (11) and (22),
subsection (a), section six of this article, regarding the
needs of medically underserved population, except in the
following cases:

(A) Where the proposed new institutional health service
is one described in subsection (f) of this section to elimi-
nate or prevent certain imminent safety hazards or to
comply with certain licensure or accreditation standards;
or

(B) Where the new institutional health service is a
proposed capital expenditure not directly related to the
provision of health services or to beds or major medical equipment.

(2) If the state agency disapproves a proposed new institutional health service for failure to meet the needs of medically underserved populations, it shall so state in a written finding.

(f) (1) Notwithstanding review criteria in section six of this article, an application for a certificate of need shall be approved, if the state agency finds that the facility or service with respect to which such capital expenditure is proposed to be made is needed and that the obligation of such capital expenditure is consistent with the state health plan, for a capital expenditure which is required:

(A) To eliminate or prevent imminent safety hazards as defined by federal, state or local fire, building or life safety codes, rules or regulations;

(B) To comply with state licensure standards; or

(C) To comply with accreditation or certification standards, compliance with which is required to receive reimbursements under Title XVIII of the Social Security Act or payments under the state plan for medical assistance approved under Title XIX of such act.

(2) An application for a certificate of need approved under this subsection shall be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards described in subparagraph (A), subdivision (1), subsection (f) of this section, or to comply with the standards described in either subparagraph (B) or (C), subdivision (1), subsection (f) of this section.

(g) The state agency shall send its decision along with written findings to the person proposing the new institutional health service or exemption and shall make it available to others upon request.

(h) In the case of a final decision to approve or approve with conditions a proposal for a new institutional health service, the state agency shall issue a certificate of need to the person proposing the new institutional health service.
(i) The state agency shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate. The state agency shall prescribe the method used to determine capital expenditure maximums and shall adopt rules pursuant to section eight of this article for the review of approved new institutional health services for which the capital expenditure maximum is exceeded or is expected to be exceeded.

(j) If the state agency fails to make a decision within the time period specified for the review, the applicant may, within one year following the expiration of such period, bring an action, at the election of the applicant, in either the circuit court of Kanawha County, or with the judge thereof in vacation, or in the circuit court of the county in which the applicant or any one of the applicants resides or does business, or with the judge thereof in vacation to require the state agency to approve or disapprove the application. An application for a proposed new institutional health service or exemption may not be approved or denied by the circuit court solely because the state agency failed to reach a decision.

§16-2D-10. Appeal of certificate of need decisions.

(a) A final decision of the state agency, including a state agency decision issued after a reconsideration, if such reconsideration was requested and granted under subsection (r), section seven of this article, and the record upon which it was made, shall upon request of any affected persons be reviewed by an agency of the State (other than the state agency) designated by the governor. To be effective, such request shall be received within thirty days after the date the affected person received notice of the state agency decision, and the hearing shall commence within thirty days of receipt of the request.

(b) To the extent not inconsistent with this section, for the purpose of administrative reviews of state agency decisions, the review agency shall conduct its proceedings in conformance with the West Virginia rules of civil procedure for trial courts of record and the local rules for use in the civil courts of Kanawha county and shall review appeals in accordance with the provisions governing the
judicial review of contested administrative cases in section
four, article five, chapter twenty-nine-a of this code, 
notwithstanding the exceptions of section five, article five, 
chapter twenty-nine-a of this code.

(c) The decision of the reviewing agency shall be made in 
writing within forty-five days after the conclusion of such 
hearing.

(d) The written findings of the review agency shall be 
sent to the person who requested the review, to the person 
proposing the new institutional health service and to the 
state agency, and shall be made available by the state 
agency to others upon request.

(e) The decision of the reviewing agency shall be consid-
ered the final decision of the state agency; however, the 
reviewing agency may remand the matter to the state 
agency for further action or consideration.

(f) Upon the entry of a final decision by the reviewing 
agency any “person adversely affected by the review” has 
standing in and may within thirty days after the date such 
person received notice of the decision of the review agency 
take an appeal at the election of the petitioner, in either 
the circuit court of Kanawha county, or in the circuit court 
of the county in which the petitioner or any of the peti-
tioners resides or does business, from any decision of the 
state agency granting, with or without conditions, denying 
or withdrawing a certificate of need or exemption. The 
decision of the review agency shall be reviewed by such 
circuit court in accordance with the provisions for the 
judicial review of administrative decisions contained in 
section four, article five, chapter twenty-nine-a of this 
code. For the purposes of this subsection, “person adver-
sely affected by the review” includes the state agency 
and any person who meets the definition of affected person 
in section two of this article.

§16-2D-11. Nontransference, time period compliance and 
withdrawal of certificate of need.

(a) A certificate of need is nontransferable and shall be 
valid for a maximum of one year from the date of issuance.
A transfer includes the sale, lease, transfer of stock or partnership shares, or other comparable arrangement which has the effect of transferring the control of the owner of the certificate of need. Upon the expiration of the certificate or during the certification period, the person proposing the new institutional health service shall provide the state agency such information on the development of the project as the state agency may request. The state agency shall periodically monitor capital expenditures obligated under certificates, determine whether sufficient progress is being made in meeting the timetable specified in the approved application for the certificate and whether there has been compliance with the application and any conditions of certification. The certificate of need may be extended by the state agency for additional periods of time as are reasonably necessary to expeditiously complete the project. A certificate of need may no longer be in effect, and may no longer be required, after written notice of substantial compliance with the approved application and any conditions of certification is issued to the applicant, after the activity is undertaken for which the certificate of need was issued, and after the state agency is provided written notice of such undertaking. The person proposing a new institutional health service may not be issued a license therefor until the state agency has issued a written notice of substantial compliance with the approved application and any conditions of certification, nor may a new institutional health service be used until such person has received such notice. A new institutional health service may not be found to be in substantial compliance with the approved application and any conditions of certification if there is a substantial change, as defined in rules adopted pursuant to subsection (b), subdivision (10), section three of this article, in the approved new institutional health service for which change a certificate of need has not been issued.

(b) (1) The certificate of need may be withdrawn by the state agency for:

(A) Insufficient progress in meeting the timetable specified in the approved application for the certificate
and for not making a good faith effort to meet it in developing the project; or

(B) Noncompliance with any conditions of certification; or

(C) A substantial change, as defined in rules adopted pursuant to subdivision (10), subsection (b), section three of this article, in an approved new institutional health service for which change a certificate of need has not been issued; or

(D) Material misrepresentation by an applicant upon which the state agency relied in making its decision; or

(E) Other reasons that may be established by the state agency in rules adopted pursuant to section eight of this article.

(2) Any decision of the state agency to withdraw a certificate of need shall be based solely on:

(A) The provisions of this article and on rules adopted in accordance with section eight of this article; and

(B) The record established in administrative proceedings held with respect to the state agency's proposal to withdraw the certificate.

(3) In the case of a proposed withdrawal of a certificate of need:

(A) After commencement of a hearing on the state agency's proposal to withdraw a certificate of need and before a decision is made on withdrawal, there may be no ex parte contacts between: (i) The holder of the certificate of need, any person acting on behalf of the holder, or any person in favor of the withdrawal; and (ii) any person in the state agency who exercises responsibility respecting withdrawal of the certificate;

(B) The state agency shall follow the notification of review provisions of subsections (g) and (h), the public hearing provisions of subsection (l), the notification of the status of review and findings provisions of subsection (o), the annual report provisions of subsection (p), and the
reconsideration provisions of subsection (r), all of section seven of this article, and the conditional decision provisions of subsection (d), and the notification of decision and findings provisions of subsection (g) of section nine of this article; and

(C) Appeals of withdrawals of certificates of need shall be made pursuant to section ten of this article.

(4) A new institutional health service may not be acquired, offered, or developed within this state if a certificate of need authorizing that new institutional health service has been withdrawn by the state agency and the acquisition, offering, or development of the new institutional health service is subject to review under this article.

§16-2D-13. Injunctive relief; civil penalty.

(a) In addition to all other remedies, and aside from various penalties provided by law, if any person acquires, offers or develops any new institutional health service for which a certificate of need is required under this article without first having a certificate of need therefor as herein provided, or violates any other provision of this article or any lawful rule promulgated thereunder, the state agency may maintain a civil action in the circuit court of the county wherein such violation has occurred, or wherein such person may be found, to enjoin, restrain or prevent such violation. No injunction bond shall be required to be filed in any such proceeding.

(b) The state agency may assess a civil penalty for violation of this article. Upon the state agency determining that there is probable cause to believe that any person is knowingly offering, developing, or has acquired any new institutional health service subject to certificate of need review without having first obtained a certificate of need therefor or that any person is otherwise in violation of the provisions of this article, or any lawful rule promulgated thereunder, the state agency shall provide such person with written notice which shall state the nature of the alleged violation and the time and place at which such person shall appear to show good cause why a civil penalty should not be imposed, at which time and place such
person shall be afforded an opportunity to cross-examine the state agency's witnesses and afforded an opportunity to present testimony and other evidence in support of his position. The hearing shall be conducted in accordance with the administrative hearing provisions of section four, article five, chapter twenty-nine-a of this code. If, after reviewing the record of such hearing, the state agency director determines that such person is in violation of the certificate of need law, the state agency shall assess a civil penalty of not less than five hundred dollars nor more than twenty-five thousand dollars. In determining the amount of the penalty, the state agency shall consider the degree and extent of harm caused by the violation and the cost of rectifying the damage. Any person assessed shall be notified of the assessment in writing, and the notice shall specify the reasons for the assessment. If the person assessed fails to pay the amount of the assessment to the state agency within thirty days, the state agency may institute a civil action in the circuit court of the county wherein such violation has occurred, or wherein such person may be found to recover the amount of the assessment. In any such civil action, the scope of the court's review of the state agency's action, which shall include a review of the amount of the assessment, shall be as provided in section four, article five, chapter twenty-nine-a of this code for the judicial review of contested administrative cases.


All rules previously promulgated to implement this article shall continue in force following the amendments to this article; except that, where such previous rules differ from the requirements of the amendments to this article, then such part of those rules are hereby abrogated and shall have no further legal effect. The state agency shall commence a review of such rules and shall promulgate revised rules.
That Joint Committee on Enrolled Bills hereby certifies that
the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the Senate.

In effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within is approved this the 6th
Day of April, 1999

Governor
PRESENTED TO THE
GOVERNOR
Date. 4/11/99
Time 10:30 am