SENATE BILL NO. 773

(By Senator Kessler, et al.)

PASSED March 11, 2006

In Effect From Passage
ENROLLED

Senate Bill No. 773

(BY SENATORS KESSLER, DEMPSEY, FANNING, HUNTER, MINARD, WHITE, BARNES, CARUTH, DEEM, LANHAM, MCKENZIE AND WEEKS)

[Passed March 11, 2006; in effect from passage.]

AN ACT to amend and reenact §16-2D-1, §16-2D-5, §16-2D-6 and §16-2D-9 of the Code of West Virginia, 1931, as amended, all relating to certificate of need standards; establishing standards for and guidance to the Health Care Authority in making amendments and modifications to certificate of need standards; setting forth factors for consideration in amending or modifying certificate of need standards and rules; identifying sources for consideration in amending or modifying certificate of need standards and methodologies; providing that applications for a certificate of need may be made subject to criteria contained in certificate of need standards; providing that decisions may be made by the Health Care Authority on applications for certificate of need standards based upon a review conducted in accordance with certificate of need standards; and clarifying the certificate of need standards are not subject to legislative rulemaking.
Be it enacted by the Legislature of West Virginia:

That §16-2D-1, §16-2D-5, §16-2D-6 and §16-2D-9 of the Code of West Virginia, 1931, as amended, be amended and reenacted, all to read as follows:

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-1. Legislative findings.

1 It is declared to be the public policy of this state:

2 (1) That the offering or development of all new institutional health services shall be accomplished in a manner which is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the institutional health services of the people of this state and to avoid unnecessary duplication of institutional health services, and to contain or reduce increases in the cost of delivering institutional health services.

3 (2) That the general welfare and protection of the lives, health and property of the people of this state require that the type, level and quality of care, the feasibility of providing such care and other criteria as provided for in this article, including certificate of need standards and criteria developed by the state agency pursuant to provisions of this article, pertaining to new institutional health services within this state, be subject to review and evaluation before any new institutional health services are offered or developed in order that appropriate and needed institutional health services are made available for persons in the area to be served.

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

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

2 (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. 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 effectiveness and access and the other purposes of this article, to allocate the supply of the 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 of this article and subsection (i) of this section 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
Notwithstanding the provisions of subsection (g) of this section 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 freestanding 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
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150 to implement this subsection which shall include a re-
151 quirement that:

152 (A) The one hundred eighty beds are to be distributed on
153 a statewide basis;

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

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

159 (D) The retirement center demonstrates a need for the
160 project;

161 (E) The retirement center offers personal care, home
162 health services and other lower levels of care to its resi-
163 dents; and

164 (F) The retirement center demonstrates both short- and
165 long-term financial feasibility.

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

170 (k) The state agency may order a moratorium upon the
171 offering or development of a new institutional health
172 service, when criteria and guidelines for evaluating the
173 need for the new institutional health service have not yet
174 been adopted or are obsolete. The state agency may also
175 order a moratorium on the offering or development of a
176 health service, notwithstanding the provisions of subdivi-
177 sion (5), subsection (b), section three of this article, when
178 it determines that the proliferation of the service may
179 cause an adverse impact on the cost of health care or the
180 health status of the public. A moratorium shall be de-
181clared by a written order which shall detail the circum-
182 stances requiring the moratorium. Upon the adoption of
183 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.

(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) When amending and modifying the certificate of need standards, the state agency shall identify relevant criteria contained in section six of this article or rules adopted pursuant to section eight of this article, and apply those relevant criteria to the proposed new institutional health service in a manner that promotes the public policy goals and legislative findings contained in section one of this article. In doing so, the state agency may consult with or rely upon learned treatises in health planning, recommendations and practices of other health planning agencies and organizations, recommendations from consumers, recommendations from health care providers, recommendations from third-party payors, materials reflecting the standard of care, the state agency's own developed expertise in health planning, data accumulated by the state agency or other local, state or federal agency or organization, and any other source deemed relevant to the certificate of need standards proposed for amendment or modification.
(3) 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.

(4) The certificate of need standards adopted pursuant to this section which are applicable to the provisions of this article are not subject to article three, chapter twenty-nine-a of this code. The state agency shall follow the provisions set forth in this subsection for giving notice to the public of its actions, holding hearings or receiving comments on the certificate of need standards. The certificate of need standards in effect on the twenty-ninth day of November, two thousand five, and all prior versions promulgated and adopted in accordance with the provisions of this section, are and have been in full force and effect from each of their respective dates of approval by the Governor.

(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, intern-ship 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 house staff and admission by personal physician;
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, in rules adopted pursuant to section eight of this article or in the certificate of need standards approved pursuant to section five 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 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 responsi-
173 ble for the provision and financing of long-term care
174 facilities or services including home health services.
175 (f) In the case where an application is made by a hospi-
176 tal, nursing home or other health care facility to provide
177 ventilator services which have not previously been pro-
178 vided for a nursing facility bed, the state agency shall
179 consider the application in terms of the need for the
180 service and whether the cost exceeds the level of current
181 Medicaid services. No facility may, by providing ventila-
182 tor services, provide a higher level of service for a nursing
183 facility bed without demonstrating that the change in level
184 of service by provision of the additional ventilator services
185 will result in no additional fiscal burden to the state.

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

§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 administra-
2 (a) Only the state agency, or the appropriate administra-
tive or judicial review body, may issue, deny or withdraw
tive or judicial review body, may issue, deny or withdraw
certificates of need, grant exemptions from certificate of
certificates of need, grant exemptions from certificate of
need reviews or determine that certificate of need reviews
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 accordance with procedures and criteria in this article, in rules adopted pursuant to section eight of this article and in the certificate of need standards approved pursuant to section five 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 condition unless the condition directly relates to criteria in this article, in rules adopted pursuant to section eight of this article or in the certificate of need standards approved pursuant to section five 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 eliminate 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.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect 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 23rd Day of

Governor 2006.