H.212

Introduced by Representative Sweaney of Windsor

Referred to Committee on

Date:

Subject: Health; hospitals; health resource allocation plan; certificate of need

Statement of purpose: This bill proposes to amend the process for developing and updating Vermont's health resource allocation plan, increase the threshold dollar amount of projects and capital expenditures for which hospitals and other health care facilities must seek a certificate of need, streamline the certificate of need process, set expiration dates for certificates of need, and make other minor changes to Vermont's regulation of hospitals and other health care facilities.

An act relating to regulation of hospitals and health care facilities

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. 18 V.S.A. § 1902(1) is amended to read:

(1) "Hospital" means a place devoted primarily to the maintenance and operation of diagnostic and therapeutic facilities for inpatient medical or surgical care of individuals suffering from illness, disease, injury or deformity, or for obstetrics. <u>The term also includes any ambulatory surgical center granted a certificate of need under chapter 221 of this title.</u>

* * *

Sec. 2. 18 V.S.A. § 9401 is amended to read:

§ 9401. POLICY

(a) It is the policy of the state of Vermont to ~~insure~~ ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

(b) It is further the policy of the state of Vermont that the health care system should:

(1) Maintain and improve the quality of health care services offered to Vermonters.

(2) Promote ~~market or other~~ planning mechanisms that contain or reduce increases in the cost of delivering services so that health care costs do not consume a disproportionate share of Vermonters' incomes or the moneys available for other services required to insure the health, safety, and welfare of Vermonters.

(3) Encourage regional and local participation in decisions about health care delivery, financing, and provider supply.

(4) Promote ~~market or other~~ planning mechanisms that will achieve rational allocation of health care resources in the state.

(5) Facilitate universal access to preventive and medically necessary health care.

(6) Support efforts to integrate mental health and substance abuse services with overall medical care.

Sec. 3. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

(1) "Commissioner" means the commissioner of the department of banking, insurance, securities, and health care administration, or the commissioner's designee.

(2) "Community report" means the hospital report prepared under section 9405a of this title.

(3) "Department" means the department of banking, insurance, securities, and health care administration.

(4) "Division" means the division of health care administration.

(5) "Expenditure analysis" means the expenditure analysis developed pursuant to section 9406 of this title.

(6) "File" means to submit a document to the department, either in writing or electronically, and includes submitting a document as an attachment to an electronic message. A document shall be considered to be filed on the date it is actually received by the department.

(7) "Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision ~~9432(7)~~9432(10) of this title, except health maintenance organizations.

~~(7)~~(8) "Health care provider" means a person, partnership, or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment, or confinement.

~~(8)~~(9) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organizations, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

~~(9)~~(10) "Health maintenance organization" means any person certified to operate a health maintenance organization by the commissioner pursuant to chapter 139 of Title 8.

~~(10)~~(11) "Health resource allocation plan" means the plan ~~developed~~ adopted by the ~~commissioner and adopted by the governor~~ secretary of human services under section 9405 of this title.

~~(11)~~(12) "Home health agency" means a for-profit or ~~not-for-profit~~ nonprofit health care facility providing part-time or intermittent skilled nursing services and at least one of the following other therapeutic services made available on a visiting basis, in a place of residence used as a patient's home: physical, speech, or occupational therapy; medical social services; home health aide services; or other non-nursing therapeutic services, including the services of nutritionists, dieticians, psychologists, and licensed mental health counselors.

~~(12)~~(13) "Home health services" means activities and functions of a home health agency, including but not limited to nurses, home health aides, physical therapists, occupational therapists, speech therapists, medical social workers, or other non-nursing therapeutic services directly related to care, treatment, or diagnosis of patients in the home.

~~(13)~~(14) "Hospital" means an acute care hospital licensed under chapter 43 of this title ~~and falling within one of the following four distinct categories, as defined by the commissioner by rule:~~

~~(A) Category A1: tertiary teaching hospitals.~~

~~(B) Category A2: regional medical centers.~~

~~(C) Category A3: community hospital systems.~~

~~(D) Category A4: critical access hospitals~~.

~~(14)~~(15) "Managed care organization" means any financing mechanism or system that manages health care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization.

~~(15)~~(16) "Public oversight commission" means the commission established in section 9407 of this title.

~~(16)~~(17) "Unified health care budget" means the budget established in accordance with section 9406 of this title.

~~(17)~~(18) "State health plan" means the plan developed under section 9405 of this title.

Sec. 4. 18 V.S.A. § 9404(e) is amended to read:

(e) There is hereby created a fund to be known as the division of health care administration regulatory and supervision fund for the purpose of providing the financial means for the commissioner of banking, insurance, securities, and health care administration to administer this chapter and section 6706 of Title 33. All fees and assessments received by the department pursuant to such administration shall be credited to this fund. All fines and administrative penalties, however, shall be deposited directly into the general fund. The commissioner shall report annually by January 15 to the house

committee on health care and the senate committee on health and welfare on the fund's sources of revenue and the fund's disbursements by program category.

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Sec. 5. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

(a) No later than January 1, 2005, the secretary of human services, in consultation with the commissioner and health care professionals and after receipt of public comment, shall adopt a state health plan that sets forth the health goals and values for the state. The secretary may amend the plan as the secretary deems necessary and appropriate. The plan shall include health promotion, health protection, nutrition, and disease prevention priorities for the state, identify available human resources as well as human resources needed for achieving the state's health goals and the planning required to meet those needs, and identify geographic parts of the state needing investments of additional resources in order to improve the health of the population. The plan shall contain sufficient detail to guide development of the state health resource allocation plan. Copies of the plan shall be submitted to members of the senate and house committees on health and welfare no later than January 15, 2005.

~~(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.~~

~~(1) The plan shall include:~~

~~(A) A statement of principles reflecting the policies enumerated in sections 9401 and 9431 of this chapter to be used in allocating resources and in establishing priorities for health services.~~

~~(B) Identification of the current supply and distribution of hospital, nursing home, and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources, federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services.~~

~~(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the~~

~~commissioner shall consider at least the following factors: the values and goals reflected in the state health plan; the needs of the population on a statewide basis; the needs of particular geographic areas of the state, as identified in the state health plan; the needs of uninsured and underinsured populations; the use of Vermont facilities by out-of-state residents; the use of out-of-state facilities by Vermont residents; the needs of populations with special health care needs; the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; the cost impact of these resource requirements on health care expenditures; the services appropriate for the four categories of hospitals described in subdivision 9402(12) of this title; the overall quality and use of health care services as reported by the Vermont program for quality in health care and the Vermont ethics network; the overall quality and cost of services as reported in the annual hospital community reports; individual hospital four-year capital budget projections; the unified health care budget; and the four-year projection of health care expenditures prepared by the division.~~

~~(2) In the preparation of the plan, the commissioner shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, payers, third-party payers, consumer representatives, and up to three members of the public oversight~~

~~commission. The advisory committee shall review drafts and provide recommendations to the commissioner during the development of the plan. Upon adoption of the plan, the advisory committee shall be dissolved.~~

~~(3) The commissioner, with the advisory committee, shall conduct at least five public hearings, in different regions of the state, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the commissioner shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the commissioner shall publish in the manner prescribed in section 174 of Title 1 the time and place of the hearing and the place and period during which to direct written comments to the commissioner. In addition, the commissioner may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.~~

~~(4) The commissioner shall develop a mechanism for receiving ongoing public comment regarding the plan and for revising it every four years or as needed. The public oversight commission shall recommend revisions to the plan at least every four years and at any other time it determines revisions are warranted.~~

~~(5) The commissioner in consultation with appropriate health care organizations and state entities shall inventory and assess existing state health~~

~~care data and expertise, and shall seek grants to assist with the preparation of any revisions to the health resource allocation plan.~~

~~(6) The plan or any revised plan proposed by the commissioner shall be the health resource allocation plan for the state after it is approved by the governor or upon passage of three months from the date the governor receives the plan, whichever occurs first, unless the governor disapproves the plan, in whole or in part. If the governor disapproves, he or she shall specify the sections of the plan which are objectionable and the changes necessary to meet the objections. The sections of the plan not disapproved shall become part of the health resource allocation plan. Upon its adoption, the plan shall be submitted to the appropriate legislative committees.~~

(b) Beginning July 1, 2010, and every fourth year thereafter, the commissioner shall adopt a health resource allocation plan for distributing health resources in this state subject to certificate of need and budget reviews.

(c) The commissioner shall establish guidelines to ensure that health resource allocation plans are developed in a consistent manner. At a minimum, the health resource allocation plan shall identify existing health care resources and include guidelines for the evaluation of certificate of need applications under this chapter. Revisions to the health resource allocation plan shall also encompass a broader assessment of system performance than that provided by hospital budgets and certificate of need reviews and shall

integrate the financial realities that affect system and individual sector performance.

(d) Prior to adoption of a health resource allocation plan, the commissioner shall hold one or more public hearings for the purpose of receiving oral and written comment on the plan developed in consultation with the public oversight commission in accordance with the provisions of subdivision 9407(b)(3) of this title. The commissioner shall also consult with health care organizations and other state entities.

Sec. 6. 18 V.S.A. § 9405a is amended to read:

§ 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

Each hospital shall have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process shall be integrated with the hospital's long-term planning and shall be described as a component of its four-year capital expenditure projections provided to the ~~public oversight commission under~~ commissioner pursuant to subdivision ~~9407(b)(2)~~ 9454(a)(6) of this title. The process shall be updated as necessary to continue to be consistent with such planning and capital expenditure projections, and identified needs shall be summarized in the hospital's community report.

Sec. 7. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The commissioner, in consultation with representatives from the public oversight commission, hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a standard format for ~~community reports, as well as the contents~~ the content of the reports, which shall include:

(1) measures of quality, including process and outcome measures, that are valid, reliable, and useful, including comparisons to appropriate national benchmarks for high quality and successful outcomes;

(2) measures of patient safety that are valid, reliable, and useful, including comparisons to appropriate industry benchmarks for safety;

(3) measures of hospital-acquired infections that are valid, reliable, and useful, including comparisons to appropriate industry benchmarks;

(4) measures of the hospital's financial health, including comparisons to appropriate national benchmarks for efficient operation and fiscal health;

(5) a summary of the hospital's budget, including revenue by source and quantification of cost shifting to private payers;

(6) measures that provide valid, reliable, useful, and efficient information for payers and the public for the comparison of charges for higher volume health care services;

(7) the hospital's process for achieving openness, inclusiveness, and meaningful public participation in its strategic planning and decision-making;

(8) the hospital's consumer complaint resolution process, including identification of the hospital officer or employee responsible for its implementation;

(9) information concerning recently completed or ongoing quality improvement and patient safety projects;

(10) a description of strategic initiatives discussed with or derived from the identification of health care needs; the one-year and four-year capital expenditure plans; and the depreciation schedule for existing facilities;

(11) information on membership and governing body qualifications, a listing of the current governing body members, and means of obtaining a schedule of meetings of the hospital's governing body, including times scheduled for public participation; and

(12) valid, reliable, and useful information on nurse staffing, including comparisons to appropriate industry benchmarks for safety. This information may include system-centered measures, such as skill mix, nursing care hours per patient day, and other such system-centered measures as reliable industry benchmarks become available in the future.

* * *

(d) New measures to be included in the reports may be adopted only in consultation with representatives from the public oversight commission, hospitals, other groups of health care professionals, and members of the public representing patient interests, and after a cost-benefit analysis has determined that the benefit of the additional reporting will outweigh the additional costs to the health care system in gathering and reporting the data.

Sec. 8. 18 V.S.A. § 9407 is amended to read:

§ 9407. PUBLIC OVERSIGHT COMMISSION; DUTIES

* * *

(b) The public oversight commission shall:

(1) review certificate of need applications and make recommendations to the commissioner;

(2) ~~review hospital one-year capital expenditure plans and four-year capital expenditure projections and engage in dialogue with hospitals regarding the health resource allocation plan and the health policy needs of the state;~~

~~(3)~~ consult with the commissioner on developing and updating hospital quality and financial measures; and

~~(4)~~(3) consult with the commissioner in the periodic updating and revision of the health resource allocation plan.

* * *

Sec. 9. 18 V.S.A. § 9408a is amended to read:

§ 9408a. UNIFORM PROVIDER CREDENTIALING

* * *

(b) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing. The commissioner may grant a hospital an extension to the implementation date for up to one year.

(c) The Vermont board of medical practice shall use the uniform credentialing form established in subsection (b) of this section for the licensure of physicians.

(d) An insurer or a hospital shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than 30 business days after the insurer or hospital receives the completed credentialing application form.

~~(d)~~(e) A hospital shall notify a provider concerning the status of the provider's completed credentialing application not later than:

(1) Sixty days after the hospital receives the completed credentialing application form; and

(2) Every 30 days after the notice is provided under subdivision (1) of this subsection, until the hospital makes a final credentialing determination concerning the provider.

~~(e)~~(f) The commissioner may enforce compliance with the provisions of this section as to insurers and as to hospitals as if the hospital were an insurer under section 3661 of Title 8.

~~(f)~~(g) An insurer shall act upon and finish the credentialing process of a completed application submitted by a provider within 60 calendar days of receipt of the application. An application shall be considered complete once the insurer has received all information and documentation necessary to make its credentialing determination as provided in subsections (b) and (c) of this section.

Sec. 10. 18 V.S.A. § 9432 is amended to read:

§ 9432. DEFINITIONS

As used in this subchapter:

(1) "Ambulatory surgical center" means a facility or portion of a facility that provides surgical care not requiring an overnight stay. The office of a dentist in which activities are limited to dentistry and oral or maxillofacial surgical procedures shall not be deemed an ambulatory surgical center for purposes of this subchapter. In order to be considered an ambulatory surgical center, a facility shall meet all the following criteria:

(A) Charge, or intend to charge, a facility fee in addition to professional fees for the services performed.

(B) Have an operating room or recovery room in the facility.

(C) Use an anesthesiologist or nurse anesthetist.

(D) Provide one or more outpatient services for which Medicare coverage is provided.

(2) "Annual operating expense" means the incremental expense that is not properly chargeable as a capital expenditure under generally accepted accounting principles and that is incurred by an applicant in connection with a new health care service during the first 12 months in which the service is in full operation after completion of the project.

~~(2)~~(3) "Applicant" means a person who has submitted an application or proposal requesting issuance of a certificate of need.

~~(3)~~(4) "Bed capacity" means the number of licensed beds operated by the facility under its most current license under chapter 43 of this title and of facilities under chapter 71 of Title 33.

~~(4)~~(5) "Capital expenditure" means an expenditure for the plant or equipment which is not properly chargeable under generally-accepted accounting principles as an expense of operation and maintenance ~~and~~. A capital expenditure includes acquisition by purchase, donation, ~~leasehold expenditure,~~ or lease which is treated as capital expense in accordance to the

accounting standards established for lease expenditures by the Financial Accounting Standards Board, calculated over the length of the lease for plant or equipment, and includes assets having an expected life of at least three years. A capital expenditure ~~includes~~ may also include the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment.

(6) "Cardiac catheterization laboratory" means a facility, or portion of a facility, in which cardiac catheterization procedures, whether diagnostic or therapeutic, are conducted.

~~(5)~~(7) "Construction" means actual commencement of any construction or fabrication of any new building, or addition to any existing facility, or any expenditure relating to the alteration, remodeling, renovation, modernization, improvement, relocation, repair, or replacement of a health care facility, including expenditures necessary for compliance with life and health safety codes.

~~(6)~~(8) "To develop," when used in connection with health services, means to undertake activities which on their completion will result in the offer of a new health care project, or the incurring of a financial obligation in relation to the offering of a service.

(9) "Diagnostic imaging facility" means a facility, or portion of a facility, that performs any of the following diagnostic services: computerized tomography, fluoroscopy, nuclear medicine, angiography, magnetic resonance imaging, or positron emission tomography.

~~(7)~~(10) "Health care facility" means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include ~~but is not limited to~~:

(A) hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the state of Vermont, or its subdivisions, or a duly authorized agency thereof; and

(B) nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, or any inpatient or ambulatory surgical, diagnostic, or treatment center.

~~(8)~~(11) "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment, or confinement.

~~(9)~~(12) "Health services" mean activities and functions of a health care facility that are directly related to care, treatment, or diagnosis of patients.

(13) "Independent diagnostic laboratory" means a laboratory, not owned or operated by a hospital, that holds itself out to other health care providers as available for the performance of diagnostic tests, and which accepts from, and performs for or on behalf of other health care providers, during any calendar year, diagnostic tests on at least 100 specimens in any one of the following categories: microbiology, serology, clinical chemistry, immunohematology, hematology, pathology, and radiobioassay.

(14) "Kidney disease treatment center" means a facility or portion of a facility that is approved to furnish kidney transplantation or inpatient, outpatient, or home dialysis.

(15) "Material change" means a change to a health care project as to which a certificate of need has been issued that:

(A) constitutes a new health care project as defined in section 9434 of this title; or

(B) increases the total costs of the project by more than 10 percent of the approved amount.

~~(10)~~(16) "Obligation" means an obligation for a capital expenditure which is deemed to have been incurred by or on behalf of a health care facility or health maintenance organization.

~~(11)~~(17) "To offer," when used in connection with health services, means that a health care provider holds itself out as capable of providing, or as having the means for the provision of, specified health services.

~~(12) "Annual operating expense" means that expense which, by generally accepted accounting principles, is incurred by a new health care service during the first fiscal year in which the service is in full operation after completion of the project.~~

(18) "Outpatient diagnostic or therapy program" means a health care program that offers diagnostic or therapeutic procedures to patients referred from health care facilities or health care providers and which seeks designation as either a comprehensive outpatient rehabilitation facility as defined in 42 C.F.R. § 485.51 or a rehabilitation agency as defined in 42 C.F.R. § 485.703.

(19) "Radiation therapy facility" means a facility or portion of a facility in which patients are treated by the use of ionizing radiation to kill cells in the region of a tumor.

(20) "Does not substantially alter services" means that:

(A) the capital or operating expenses associated with a proposed new health care project are reasonable in light of the scope of the project;

(B) the proposed new health care project does not have a significant impact on services already being provided, the cost of health care, or on the financial strength of the applicant; and

(C) the proposed new health care project does not raise any significant health care policy or planning concerns.

Sec. 11. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the commissioner. For purposes of this subsection, a "new health care project" includes the following:

(1) The construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds ~~$1,500,000.00~~ $2,500,000.00, provided that expenses incurred for core infrastructure such as a new roof or heating system shall not be subject to review.

(2) A change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.

(3) The offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest of a home health agency.

(4) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of ~~$1,000,000.00~~ $1,500,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision 9432(7)(B) of this title, as determined by the commissioner, shall be considered together in calculating the amount of an expenditure. The commissioner's determination of ~~functional interdependence of items of equipment under this subdivision~~ the costs of all components that are integral to the equipment and necessary to make it function shall have the effect of a final decision and is subject to appeal under this subchapter.

(5) The offering of a health care service or technology having an annual operating expense which exceeds ~~$500,000.00~~ $600,000.00 for either ~~of the~~

~~next two budgeted fiscal years~~ the first 12-month period in which the services is in full operation after being implemented or the second 12-month period after implementation, if the service or technology was not offered or employed by the health care facility within the previous ~~three fiscal years~~ 36 months preceding the application, either on a fixed or a mobile basis.

(6) Notwithstanding the provisions of subdivisions (1) through (5) of this subsection, inclusive, no certificate of need for an ambulatory surgical center may be granted prior to July 1, 2014.

(b) A hospital shall not develop or have developed on its behalf a new health care project without issuance of a certificate of need by the commissioner. For purposes of this subsection, a "new health care project" includes the following:

(1) The construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a hospital, for which the capital cost exceeds ~~$3,000,000.00~~ $4,000,000, provided that expenses incurred for core infrastructure such as a new roof or heating system shall not be subject to review.

(2) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of ~~$1,000,000.00~~ $1,500,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of

diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision 9432(7)(B) of this title, as determined by the commissioner, shall be considered together in calculating the amount of an expenditure. The commissioner's determination of ~~functional interdependence of items of equipment under this subdivision~~ the costs of all components that are integral to the equipment and necessary to make it function shall have the effect of a final decision and is subject to appeal under this subchapter.

(3) The offering of a health care service or technology having an annual operating expense which exceeds ~~$500,000.00~~ $600,000.00 for either ~~of the next two budgeted fiscal years~~ the first 12-month period in which the service is in full operation after being implemented or the second 12-month period after implementation, if the service or technology was not offered or employed by the hospital within the ~~previous three fiscal years~~ 36 months preceding the application, either on a fixed or a mobile basis.

(4) A change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.

(c)(1) In the case of a project which requires a certificate of need under this section, expenditures for which are anticipated to be in excess of

$30,000,000.00, the applicant first shall secure a conceptual development phase certificate of need, in accordance with the standards and procedures established in this subchapter, which permits the applicant to make expenditures for architectural services, engineering design services, or any other planning services, as defined by the commissioner, needed in connection with the project. Upon completion of the conceptual development phase of the project, and before offering or further developing the project, the applicant shall secure a final certificate of need, in accordance with the standards and procedures established in this subchapter. Applicants shall not be subject to sanctions for failure to comply with the provisions of this subsection if such failure is solely the result of good faith reliance on verified project cost estimates issued by qualified persons, which cost estimates would have led a reasonable person to conclude the project was not anticipated to be in excess of $30,000,000.00 and therefore not subject to this subsection.

(2) ~~The provisions of this subsection notwithstanding~~ Notwithstanding the provisions of subdivision (1) of this subsection, expenditures may be made in preparation for obtaining a conceptual development phase certificate of need, which expenditures shall not exceed $1,500,000.00 for non-hospitals or $3,000,000.00 for hospitals.

(3) A conceptual development phase certificate of need shall be eligible for expedited review pursuant to subsection 9440(e) of this title.

(4) Proposals for a certificate of need for investments in health information technology shall not be required to obtain a conceptual development phase certificate of need.

(d) If the commissioner determines that a person required to obtain a certificate of need under this subchapter has separated a single project into components in order to avoid cost thresholds or other requirements under this subchapter, the person shall be required to submit an application for a certificate of need for the entire project, and the commissioner may proceed under section 9445 of this title. The commissioner's determination under this subsection shall have the effect of a final decision and is subject to appeal under this subchapter.

(e) Beginning January 1, 2005, and biannually thereafter, the commissioner may by rule adjust the monetary jurisdictional thresholds contained in this section. In doing so, the commissioner shall reflect the same categories of health care facilities, services, and programs recognized in this section. Any adjustment by the commissioner shall not exceed the consumer price index rate of inflation.

Sec. 12. 18 V.S.A. § 9434a is added to read:

§ 9434a. CALCULATING EXPENDITURES FOR JURISDICTIONAL DETERMINATIONS

When calculating the anticipated expenditure on a proposed health care project for jurisdictional purposes pursuant to section 9434 of this title, the commissioner shall include only the following costs or expenditures:

(1) For capital expenditures pursuant to subdivisions 9434(a)(1) and (b)(1) of this title, all expenditures associated with the project that are properly chargeable under generally-accepted accounting principles as capital expenditures. Expenditures that under generally-accepted accounting principles are properly chargeable as operating expenses are not includable as capital expenditures for jurisdictional or review purposes.

(2) For diagnostic or therapeutic equipment pursuant to subdivision 9434(a)(4) or (b)(2) of this title, if the equipment is being acquired through a donation, the value means the average price of the same or substantially similar equipment as determined by the ECRI Institute. If the equipment is being acquired other than through a donation, the cost is the negotiated purchase price of the equipment before any trade-in value of existing equipment is applied. If the acquisition of the equipment is financed by a lease transaction, the cost of the equipment shall not include the financing or interest costs associated with the loan or lease transaction. Construction, renovation, and

other fit-up costs associated with acquiring the equipment are not includable in the cost of the equipment for jurisdictional or review purposes, but may be included as capital expenditures for purposes of determining jurisdiction pursuant to subdivision 9434(a)(1) or (b)(1) of this title.

(3) For annual operating expense pursuant to subdivision 9434(a)(5) or (b)(3) of this title, those operating expenses that would be incurred for the service or technology over and above any operating expenses that would be incurred by the health care facility in the normal course of business if the service or technology were not being offered.

Sec. 13. 18 V.S.A. § 9439 is amended to read:

§ 9439. COMPETING APPLICATIONS

(a) The commissioner shall provide by rule a process by which any person wishing to offer or develop a new health care project may submit a competing application when a substantially similar application is pending. The competing application must be filed and completed in a timely manner, and the original application and all competing applications shall be reviewed concurrently. A competing applicant shall have the same standing for administrative and judicial review under this subchapter as the original applicant.

(b) When a letter of intent to compete has been filed, the review process is suspended and the time within which a decision must be made as provided in subdivision 9440(d)(4) of this title is stayed until the competing application

has been ruled complete or for a period of 55 days from the date of notification under subdivision 9440(c)(8) as to the original application, whichever is shorter.

(c) Nothing in this subchapter shall be construed to restrict the commissioner to granting a certificate of need to only one applicant for a new health care project.

(d) The commissioner may, by rule, establish regular review cycles for the addition of beds for skilled nursing or intermediate care.

(e) In the case of proposals for the addition of beds for skilled nursing or intermediate care, the commissioner shall identify in advance of the review the number of additional beds to be considered in that cycle or the maximum additional financial obligation to be incurred by the agencies of the state responsible for financing long-term care. The number of beds shall be consistent with the number of beds determined to be necessary by the health resource management plan or state health plan, whichever applies, and shall take into account the number of beds needed to develop a new, efficient facility.

~~(f) The commissioner shall establish, by rule, annual cycles for the review of applications for certificates under this subchapter, in addition to the review cycles for skilled nursing and intermediate care beds established under subsections (d) and (e) of this section. A review cycle may include in the same~~

~~group some or all of the types of projects subject to certificate of need review. Such rules may exempt emergency applications, pursuant to subsection 9440(d) of this title.~~

Sec. 14. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

(a) Notwithstanding chapter 25 of Title 3, a certificate of need application shall be in accordance with the procedures of this section.

(b)(1) The application shall be in such form and contain such information as the commissioner establishes. In addition, the commissioner may require of an applicant any or all of the following information that the commissioner deems necessary, as long as such information can be produced at a reasonable cost, which shall be no more than $10,000.00 for noncapital projects and no more than 0.5 percent of the cost of a capital project:

(A) institutional utilization data, including an explanation of the unique character of services and a description of case mix;

(B) a population based description of the institution's service area;

(C) the applicant's financial statements;

(D) third party reimbursement data;

(E) copies of feasibility studies, surveys, designs, plans, working drawings, or specifications developed in relation to the proposed project;

(F) annual reports and four-year long range plans;

(G) leases, contracts, or agreements of any kind that might affect quality of care or the nature of services provided;

(H) the status of all certificates issued to the applicant under this subchapter during the three years preceding the date of the application. As a condition to deeming an application complete under this section, the commissioner may require that an applicant meet with the commissioner to discuss the resolution of the applicant's compliance with those prior certificates; and

(I) additional information as needed by the commissioner.

(2) In addition to the information required for submission, an applicant may submit, and the commissioner shall consider, any other information relevant to the application or the review criteria.

(c) The application process shall be as follows:

(1) ~~Applications shall be accepted only at such times as the commissioner shall establish by rule.~~

~~(2)~~ Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the commissioner no less than 30 days or, in the case of review cycle applications under section 9439 of this title, no less than 45 days prior to the date on which the application is to be filed. The letter of intent shall form the basis for determining the applicability of this subchapter to the proposed expenditure or action. A letter of intent shall

become invalid if an application is not filed within six months of the date that the letter of intent is received or, in the case of review cycle applications under section 9439 of this title, within such time limits as the commissioner shall establish by rule. Except for requests for expedited review under subdivision (5) of this subsection, public notice of such letters of intent shall be provided in newspapers having general circulation in the region of the state affected by the letter of intent. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice shall be sent to the clerk of the municipality in which the health care facility is located. Upon receipt, the clerk shall post the notice in or near the clerk's office and in at least two other public places in the municipality.

~~(3)~~(2) The commissioner shall review each letter of intent and, if the letter contains the information required for letters of intent as established by the commissioner by rule, within 30 days, determine whether the project described in the letter will require a certificate of need. If the commissioner determines that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need shall be filed before development of the project begins.

(3) Applicants who agree that their proposals are subject to jurisdiction pursuant to section 9434 of this title shall not be required to file a letter of

intent pursuant to subdivision (1) of this subsection and may file an application without further process. The commissioner shall issue public notice of such applications in the same manner as outlined for letters of intent under subdivision (1) of this subsection.

(4) Within 90 days of receipt of an application, the commissioner shall notify the applicant that the application contains all necessary information required and is complete, or that the application review period is complete notwithstanding the absence of necessary information. The commissioner may extend the 90-day application review period for an additional 60 days, or for a period of time in excess of 150 days with the consent of the applicant. The time during which the applicant is responding to the commissioner's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The public oversight commission may recommend, or the commissioner may determine that the certificate of need application shall be denied if the applicant has failed to provide all necessary information required to review the application. In requesting additional information pursuant to this subdivision, the commissioner shall ensure that the questions are directly related to applicable review criteria, shall endeavor to batch questions about similar criteria to the extent possible, and shall limit the number of separate requests to the minimum necessary.

(5) An applicant seeking expedited review of a certificate of need application may simultaneously file a letter of intent and an application with the commissioner. Upon making a determination that the proposed project may be uncontested and does not substantially alter services, ~~as defined by rule,~~ or upon making a determination that the application relates to a health care facility affected by bankruptcy proceedings, the commissioner shall issue public notice of the application and the request for expedited review and identify a date by which a competing application or petition for interested party status must be filed. If a competing application is not filed and no person opposing the application is granted interested party status, the commissioner may formally declare the application uncontested and may issue a certificate of need without further process, or with such abbreviated process as the commissioner deems appropriate. If a competing application is filed or a person opposing the application is granted interested party status, the applicant shall follow the certificate of need standards and procedures in this section, except that in the case of a health care facility affected by bankruptcy proceedings, the commissioner after notice and an opportunity to be heard may issue a certificate of need with such abbreviated process as the commissioner deems appropriate, notwithstanding the contested nature of the application.

(6) If an applicant fails to respond to an information request under subdivision (4) of this subsection within six months or, in the case of review

cycle applications under section 9439 of this title, within such time limits as the commissioner shall establish by rule, the application will be deemed inactive unless the applicant, within six months, requests in writing that the application be reactivated and the commissioner grants the request. If an applicant fails to respond to an information request within 12 months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the commissioner shall establish by rule, the application will become invalid unless the applicant requests, and the commissioner grants, an extension.

(7) For purposes of this section, "interested party" status shall be granted to persons or organizations representing the interests of persons who demonstrate that they will be substantially and directly affected by the new health care project under review, meaning that they have a direct financial or other business interest in the proposed project. Persons able to render material assistance to the commissioner by providing nonduplicative evidence relevant to the determination may be admitted in an amicus curiae capacity but shall not be considered parties. A petition seeking party or amicus curiae status must be filed within 20 days following public notice of the letter of intent, or within 20 days following public notice that the application is complete. The commissioner shall grant or deny a petition to intervene under this subdivision within 15 days after the petition is filed. The commissioner shall grant or deny

the petition within an additional 30 days upon finding that good cause exists for the extension. Once interested party status is granted, the commissioner shall provide the information necessary to enable the party to participate in the review process. Such information includes information about procedures, copies of all written correspondence, and copies of all entries in the application record.

(8) Once an application has been deemed to be complete, public notice of the application will be provided in newspapers having general circulation in the region of the state affected by the application. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application under section 9439 of this title or a petition to intervene must be filed.

(9) The health care ombudsman's office established under subchapter 1A of chapter 107 of Title 8 or, in the case of nursing homes, the long-term care ombudsman's office established under section 7502 of Title 33, is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered an interested party in such proceedings upon filing a notice of intervention with the commissioner.

(d) The review process shall be as follows:

(1) The public oversight commission shall review:

(A) The application materials provided by the applicant.

(B) The assessment of the applicant's materials provided by the department. This assessment shall identify the review criteria that apply to the application and further identify any criteria as to which the applicant has not satisfied the department's questions or that implicate health policy considerations. The assessment shall serve as the focus of the public hearing on the application.

(C) Any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) The public oversight commission shall hold a public hearing during the course of a review.

(3) The public oversight commission shall make a written findings and a recommendation to the commissioner in favor of or against each application. A record shall be maintained of all information reviewed in connection with each application.

(4) A review shall be completed and the commissioner shall make a final decision within 120 days after the date of notification under subdivision (c)(4) of this section. Whenever it is not practicable to complete a review within 120 days, the commissioner may extend the review period up to an additional 30 days. Any review period may be extended with the written consent of the applicant and all other applicants in the case of a review cycle process.

(5) After reviewing each application and after considering the recommendations of the public oversight commission, the commissioner shall make a decision either to issue or to deny the application for a certificate of need. The decision shall be in the form of an approval in whole or in part, or an approval subject to such conditions as the commissioner may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the commissioner shall not mandate a new health care project not proposed by the applicant or mandate the deletion of any existing service. Any partial approval or conditional approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application.

(6)(A) If the commissioner proposes to render a final decision denying an application in whole or in part, or approving a contested application, the commissioner shall serve the parties with notice of a proposed decision containing proposed findings of fact and conclusions of law, and shall provide the parties an opportunity to file exceptions and present briefs and oral argument to the commissioner. The commissioner may also permit the parties to present additional evidence.

(B) If the commissioner's proposed decision is contrary to the recommendation of the public oversight commission:

(i) the notice of proposed decision shall contain findings of fact and conclusions of law demonstrating that the commissioner fully considered all the findings and conclusions of the public oversight commission and explaining why his or her proposed decision is contrary to the recommendation of the public oversight commission and necessary to further the policies and purposes of this subchapter; and

(ii) the commissioner shall permit the parties to present additional evidence.

(7) Notice of the final decision shall be sent to the applicant, competing applicants, and interested parties. The final decision shall include written findings and conclusions stating the basis of the decision.

(8) The commissioner shall establish rules governing the compilation of the record used by the public oversight commission and the commissioner in connection with decisions made on applications filed and certificates issued under this subchapter.

(e) The commissioner shall adopt rules governing procedures for the expeditious processing of applications for replacement, repair, rebuilding, or reequipping of any part of a health care facility or health maintenance organization destroyed or damaged as the result of fire, storm, flood, act of God, or civil disturbance, or any other circumstances beyond the control of the applicant where the commissioner finds that the circumstances require action

in less time than normally required for review. If the nature of the emergency requires it, an application under this subsection may be reviewed by the commissioner only, without notice and opportunity for public hearing or intervention by any party.

(f) Any applicant, competing applicant, or interested party aggrieved by a final decision of the commissioner under this section may appeal the decision to the supreme court. If the commissioner's decision is contrary to the recommendation of the public oversight commission, the standard of review on appeal shall require that the commissioner's decision be supported by a preponderance of the evidence in the record.

(g) If the commissioner has reason to believe that the applicant has violated a provision of this subchapter, a rule adopted pursuant to this subchapter, or the terms or conditions of a prior certificate of need, the commissioner may take into consideration such violation in determining whether to approve, deny, or approve the application subject to conditions. The applicant shall be provided an opportunity to contest whether such violation occurred, unless such an opportunity has already been provided. The commissioner may impose as a condition of approval of the application that a violation be corrected or remediated before the certificate may take effect.

Sec. 15. 18 V.S.A. § 9441 is amended to read:

§ 9441. FEES

(a) The commissioner shall charge a fee for the filing of certificate of need applications. The fee shall be calculated at the rate of 0.125 percent of project costs.

(b) The maximum fee shall not exceed $20,000.00 and the minimum filing fee is $250.00 regardless of project cost. No fee shall be charged on projects amended as part of the review process.

(c) The commissioner may retain such additional professional or other staff as needed to assist in particular proceedings under this subchapter and may assess and collect the reasonable expenses for such additional staff from the applicant. The commissioner shall give notice to the applicant of the commissioner's intent to retain such additional staff and of the estimated costs thereof, and the applicant shall have an opportunity to contest the proposed retention or the reasonableness of the proposed costs. In addition, after the additional staff has been engaged, the commissioner, on petition by the applicant and opportunity for hearing, may reduce such assessment upon a proper showing by the applicant that such expenses were excessive or unnecessary. The authority granted to the commissioner under this section is in addition to any other authority granted to the commissioner under law.

Sec. 16. 18 V.S.A. § 9443 is amended to read:

§ 9443. EXPIRATION AND TRANSFER OF CERTIFICATES OF NEED

~~The commissioner shall adopt rules providing for the expiration of certificates of need.~~

(a) Certificates of need shall expire upon the occurrence of the earliest of the following:

(1) The date the commissioner accepts the final implementation report filed in connection with a project implemented pursuant to a certificate of need;

(2) Five years after the certificate was issued by the commissioner; or

(3) Some other period expressly stated in the certificate of need, which shall not exceed five years except in the case of major capital projects or projects that the applicant agrees cannot reasonably be implemented within five years.

(b) No later than 180 days before the expiration date of a certificate of need, an applicant that has not yet implemented the project approved in the certificate of need may petition the commissioner for an extension of the implementation period. The commissioner may grant an extension in his or her discretion.

(c) An action or expenditure that is related to a service or expenditure that was the subject of a certificate of need shall not be considered a material

change to that project if the original certificate of need expired, as provided in this section, at least two years before the action is proposed. Any such proposed action would require a certificate of need only if the change itself would be considered a new health care project under section 9434 of this title.

(d) A health care facility with a valid certificate of need that has not yet been implemented and has not expired and which wishes to transfer the certificate to another health care facility must notify the commissioner about the proposed transfer. If the commissioner determines that the proposed transfer will materially change the scope of the project as approved, the commissioner may require such further process as he or she determines is necessary, which may include a public hearing. If the commissioner determines that the proposed transfer does not materially change the scope of the project as approved, the commissioner shall so notify the health care facility and the transfer may be made without further process.

Sec. 18. 18 V.S.A. § 9444 is amended to read:

§ 9444. REVOCATION OF CERTIFICATES; MATERIAL CHANGE

(a) The commissioner may revoke a certificate of need for substantial noncompliance with the scope of the project as designated in the application, or for failure to comply with the conditions set forth in the certificate of need granted by the commissioner. In the event that after a project has been approved, its proponent wishes to ~~materially change~~ make a material change to

the scope or cost of the approved project, all such changes are subject to review under this subchapter. ~~If a change itself would be considered a new health care project as defined in section 9434 of this title, it shall be considered as material. If the change itself would not be considered a new health care project as defined in section 9434 of this title, the commissioner may decide not to review the change and shall notify the applicant and all parties of such decision. Where the commissioner decides not to review a change, such change will be deemed to have been granted a certificate of need.~~

(b) Additional costs directly related to "green projects" and projects endorsed by Efficiency Vermont shall not be counted toward the material change threshold.

Sec. 19. 18 V.S.A. § 9451 is amended to read:

§ 9451. DEFINITIONS

As used in this subchapter:

(1) "Hospital" means a general hospital licensed under chapter 43 of this title and any ambulatory surgical center granted a certificate of need under this chapter.

* * *

Sec. 20. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

* * *

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the health resource allocation plan;

(2) take into consideration national, regional, or instate peer group norms, according to indicators, ratios, and statistics established by the commissioner;

(3) promote efficient and economic operation of the hospital;

(4) reflect budget performances for prior years; ~~and~~

(5) include a finding that the analysis provided in subdivision (b)(9) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers; and

(6) hold hospitals harmless for underpayments from publicly funded or publicly subsidized health plans, including Medicare, Medicaid, and Catamount Health.

* * *

Sec. 21. 18 V.S.A. § 1141(i) is amended to read:

~~(i) A laboratory having personal knowledge of a test result under this section shall transmit within 24 hours a report thereof to the department of health pursuant to subsection 1001(k) of this title.~~

Sec. 22. 18 V.S.A. § 1001(k) is amended to read:

(k) The commissioner ~~shall maintain a separate database of reports received pursuant to subsection 1141(i) of this title~~ may compile a report

documenting exposures using the information gathered by employers in their OSHA 300 log for the purpose of tracking the number of tests performed pursuant to subchapter 5~~,~~ of chapter 21 of this title and such other information as the department of health determines to be necessary and appropriate. The ~~database~~ report shall not include any information that personally identifies a patient.