NO. 53. AN ACT RELATING TO HOSPITAL AND HEALTH CARE SYSTEM ACCOUNTABILITY, CAPITAL SPENDING, AND ANNUAL BUDGETS.

(H.128)

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

Sec. 1. PURPOSE

The purpose of this act is to:

(1) strengthen the health planning process and to reflect concerns about health care access, quality, and costs;

(2) develop tools and resources to assist consumers and payers with making health care decisions by providing accessible, useful information comparing hospital costs and performance;

(3) require consistent and open dialogue between hospitals and their communities regarding health service needs, strategic planning, and health policy;

(4) increase opportunities for public involvement in health policy planning;

(5) develop a health resource allocation plan that can guide health facility planning, capital expenditures, and budget reviews; and

(6) create an efficient and effective regulatory system that is fair, predictable, enforceable, and capable of achieving Vermont's health care cost containment and other health care policy goals.

* * * General Provisions * * *

Sec. 2. 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 needs assessment" means a process by which a hospital identifies and prioritizes the health care needs of the service area or patient population for which a hospital provides services, as required by subsection 9504(c) of this title.

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

~~(2)~~(4) "Department" means the department of banking, insurance, securities, and health care administration.

~~(3)~~(5) "Division" means the division of health care administration.

~~(4)~~(6) "Expenditure analysis" means the expenditure analysis developed pursuant to section 9406 of this title.

~~(5)~~(7) "Health care facility" means all ~~facilities and~~ 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 ~~facilities and~~ institutions included in ~~section 9432(10)~~ subdivision 9432(7) of this title, except health maintenance organizations.

~~(6)~~(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.

~~(7)~~(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.

~~(8) "Health resource management plan" means the plan for distribution of the health care resources in Vermont adopted March 15, 1996.~~

~~(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.

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

(12) "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.

~~(10)~~(13) "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.

~~(11)~~(14) "Public oversight commission" means the commission established in section 9407 of this title.

~~(12) "Resident" means a person who is domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.~~

~~(13)~~(15) "Unified health care budget" means the budget established in accordance with section 9406 of this title.

~~(14)~~(16) "State health plan" means the plan developed under section 9405 of this title.

~~(15) "Technical panel" means the panel established in section 9407 of this title.~~

Sec. 3. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ~~MANAGEMENT~~ ALLOCATION PLAN~~; STATE HEALTH PLAN~~

(a) No later than ~~March 15, 1999~~ 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~~, after receipt of public comment~~. 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) ~~In order to attain the goals of the state plan, no later than March 15, 1999, and annually on January 1 thereafter, the secretary shall adopt a state health action plan that outlines the priorities and concerns for that year. The action plan shall consider the changing realities of the health care distribution system and the needs and values of the state. The secretary may consult other health care plans created by the state or any of its subdivisions or any persons that create or compile health care information to the extent the secretary determines such consultations are useful in formulating the state health action plan. On January 1, 2000, and annually thereafter, the secretary shall report to the general assembly on the success in meeting the goals of the annual state health action plan and the state health plan~~ 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; information from the hospital community needs assessments; 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 biannually or as needed, in consultation with the public oversight commission.

(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 the health resource allocation plan. Based on this assessment and no later than January 15, 2004, the commissioner shall submit a report to the general assembly stating his or her recommendations regarding the professional assistance, budget, staff, and process needed to integrate available health care data and expertise into the health resource allocation plan.

(6) The commissioner may retain such professional staff or other staff as needed to assist in his or her responsibilities under this section. The reasonable expenses of such staff shall be funded to the maximum extent possible with grant money. Any additional amounts needed, not to exceed $300,000.00, shall be assessed and collected from hospitals licensed under chapter 43 of this title, proportionate to their annual operating budgets. The commissioner's assessment authority under this subdivision shall begin on July 1, 2003 and shall expire on July 1, 2005.

(7) 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.

~~(c) Prior to adoption of a state health plan, the health resource management plan shall continue in effect until March 14, 1999.~~

Sec. 4. 18 V.S.A. § 9405a is added to read:

§ 9405a. COMMUNITY NEEDS ASSESSMENT AND STRATEGIC PLANNING

On or before January 1, 2005, each hospital shall conduct a four-year community needs assessment. The assessment shall identify and prioritize the health care needs of the service area or patient population for which a hospital provides services, and engage the public in the hospital's strategic planning process. It shall be accomplished in collaboration with community

members, including other health care professionals in the community, local government officials, community organizations, and local businesses. The process for assessing the community's health care needs shall include at least one public meeting held solely for soliciting public comment, notice for which shall be provided pursuant to section 174 of Title 1. The needs assessment shall be prepared in a uniform format approved by the commissioner and shall be summarized in the hospital's community report. In addition, each hospital shall develop a mechanism for receiving ongoing public comment, including an annual public meeting, regarding the community needs assessment and for revising it biannually so that the assessment will continue to project a four-year vision.

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

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The commissioner, in consultation with representatives from the public oversight commission, hospitals, and other groups of health care professionals shall adopt rules establishing a standard format for community reports, as well as the contents, 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 the hospital's financial health, including comparisons to appropriate national benchmarks for efficient operation and fiscal health;

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

(5) 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;

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

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

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

(9) a summary of the community needs assessment, including a description of strategic initiatives discussed with or derived from the assessment; the one-year and four-year capital expenditure plans; and the depreciation schedule for existing facilities; and

(10) 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.

(b) On or before January 1, 2005, and annually thereafter, the board of directors or other governing body of each hospital licensed under chapter 43 of this title shall publish its community report in a uniform format approved by the commissioner, and in accordance with the standards and procedures adopted by rule under this section, and shall hold one or more public hearings to permit community members to comment on the report. Notice of meetings shall be by publication, consistent with section 174 of Title 1. Hospitals located outside this state

which serve a significant number of Vermont residents, as determined by the commissioner, shall be invited to participate in the community report process established by this subsection.

(c) The community reports shall be provided to the public oversight commission and the commissioner. The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 6. 18 V.S.A. § 9406 is amended to read:

§ 9406. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET

(a) ~~Beginning July 1, 1994, and annually thereafter~~ Annually, the commissioner shall ~~adopt~~ develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in section 9401 of this title.

(1) The budget shall:

(A) Serve as ~~the basic framework~~ a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont, and for all health care services provided to residents of this state.

(C) ~~Be consistent with the health resource management plan or~~ Identify any inconsistencies with the state health plan~~, whichever applies~~ and the health resource allocation plan.

~~(2)~~(D) ~~When preparing the budget, the commissioner shall consider~~ Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

~~(3) Based on the advice and recommendations of the technical panel, the commissioner shall adopt, by rule, the various sectors of the health care system to be separately identified in the budget, the methods and processes to be used to allocate resources among such sectors, the economic indicators to be used to define the parameters of the rate of growth in the cost of the system and various sectors of the system, and processes and criteria for responding to exceptional and unforeseen circumstances which affect the system and the budget.~~

~~(4)~~(2) The commissioner shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.

(b)(1) Annually the division ~~of health care administration~~ shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the commissioner under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) ~~Expenditures~~ expenditures for the health plans of any hospital and medical service corporation, health maintenance organizations, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population~~.~~; and

(B) ~~Expenditures~~ expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the division's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a

description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year, and an evaluation of the efficacy of any cost containment efforts the plan has made.

(3) The division's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department~~. The division's projections~~ and shall be made available ~~to the public oversight commission~~ in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The division shall prepare a report of the final projections made under this subsection, and file the report with the general assembly on or before ~~January 1, 1999, and annually thereafter on~~ January 1 of each year.

Sec. 7. 18 V.S.A. § 9407 is amended to read:

§ 9407. PUBLIC OVERSIGHT COMMISSION; ~~TECHNICAL PANEL~~ DUTIES

(a) With the advice and consent of the senate, the governor shall appoint a public oversight commission ~~to be composed~~ of 13 members who shall reflect in the broadest sense the various health care needs and the demographic and geographic diversity of the state of Vermont. ~~Nine members shall be sitting members, and four members shall be designated alternates to be assigned to create a quorum or to replace any sitting member who has a conflict of interest.~~ The governor shall appoint a chair. Members of the commission shall be appointed for staggered terms of three years and shall serve no more than two consecutive terms. ~~The commission shall review hospital budgets and certificate of need applications and make recommendations thereon to the commissioner.~~

(b) ~~The commissioner shall appoint a technical panel to be composed of nine members and shall designate a chair. The panel shall include experts in medicine, law, business, hospital administration, economics and consumer health care issues. The technical panel shall advise the public oversight commission and the commissioner on technical matters arising under this chapter relating to the unified health care budget, resource allocation, utilization review recommendations, hospital budgets, quality assurance, the state health plan, and make recommendations regarding amendments to the health resource management plan and any other matter the commissioner may deem appropriate. The commissioner may impanel additional members as needed to advise on specific technical issues, who shall not serve as permanent members.~~

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

(c) Members of the public oversight commission ~~and members of the technical panel~~ shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).

(d) The public oversight commission shall rely on the department for administrative support.

* * * Health Facility Planning * * *

Sec. 8. 18 V.S.A. § 9431 is amended to read:

§ 9431. POLICY AND PURPOSE

(a) It is declared to be the public policy of this state that the general welfare and protection of the lives, health and property of the people of this state require that all new ~~institutional health services~~ health care projects be offered or developed in a manner which avoids unnecessary duplication~~,~~ and contains or reduces increases in the cost of delivering services, while at the same time ~~maintain~~ maintaining and ~~improve~~ improving the quality of and access to health care services, and ~~promotes~~ promoting rational allocation of health care resources in the state; and that the need, cost, type, level, quality, and feasibility of providing any new ~~institutional health services~~ health care project be subject to review and assessment prior to any offering or development.

(b) In order to carry out the policy goals of this subchapter, the department shall ~~develop~~ adopt by rule by October 1, 2005 certificate of need procedural guidelines to assist in its decision-making. The ~~certificate of need~~ guidelines shall be consistent with the state health plan and the health resource allocation plan.

Sec. 9. 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) "Applicant" means a person who has submitted an application or proposal requesting issuance of a certificate of need.

(3) "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) "Capital expenditure" means an expenditure for the plant or equipment which~~, under generally accepted accounting principles,~~ is not properly chargeable as an expense of operation and maintenance and includes acquisition by purchase, donation ~~or~~, leasehold expenditure, or operating lease 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 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.

(5) "Construction" ~~includes~~ means actual commencement of any construction or fabrication of any new building, or addition to any existing facility, or any expenditure ~~of more~~

~~than $750,000.00~~ 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) "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 ~~institutional health service~~ health care project, or the incurring of a financial obligation in relation to the offering of a service.

(7) "Health care facility" means all ~~facilities and~~ 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 ~~facility~~ 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 health related therapeutic community residences~~;

(B) nursing homes, ~~intermediate care facilities for the mentally retarded, homes for the terminally ill~~ 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) "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) "Health services" mean activities and functions of a health care facility that are directly related to care, treatment, or diagnosis of patients.

(10) ~~"Home for the terminally ill" means a place providing services specifically for three or more dying people, including room, board, personal care and other assistance for the residents' emotional, spiritual and physical well-being.~~

~~(11)~~ "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.

~~(12)~~(11) "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.

~~(13)~~(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.

~~(14) "Cardiac catheterization laboratory" means a facility, or portion of a facility, in which cardiac catheterization procedures, whether diagnostic or therapeutic, are conducted.~~

Sec. 10. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) ~~No~~ A health care facility other than a hospital shall not develop, or have developed on its behalf a new ~~institutional health service shall be offered or developed within this state by any person,~~ health care project without ~~a determination of need and~~ issuance of a certificate of need

by the commissioner~~, as provided in this subchapter~~. ~~"New institutional health service"~~ For purposes of this subsection, a "new health care project" includes the following:

(1) ~~the~~ The construction, development, purchase, renovation, or other establishment of a ~~new~~ health care facility ~~except for the purchase or lease of an existing health care facility other than the purchase of a hospital~~, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds $1,500,000.00.

(2) ~~any expenditure by or on behalf of a hospital in excess of $1,500,000.00 or any expenditure by or on behalf of any other health care facility in excess of $750,000.00, which, under generally accepted accounting principles, consistently applied, is a capital expenditure;~~

~~(3) acquisition by purchase, or by lease or other comparable arrangement, by or on behalf of a health care provider of a single piece of diagnostic or therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $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 section 9432(10)(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 shall have the effect of a final decision and is subject to appeal under this subchapter.~~

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

~~(5)~~(3) ~~the offering of health services in or through a health care facility which were not offered on a regular basis in or through such health care facility within the twelve-month period prior to the time such services would be offered if such services have an annual operating expense in excess of $300,000.00 or the~~ The offering of any home health service~~;~~.

~~(6) the purchase of an existing hospital;~~

~~(7) the offering of any cardiac catheterization laboratory service~~

(4) The purchase, lease, or other comparable arrangement of a single piece of durable medical equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. 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 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 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed by the health care facility within the previous three fiscal years.

(b) A health care facility other than a hospital that proposes to develop a project described in subdivision (1) or (4) of subsection (a) of this section which is exempt from the requirements of this subchapter solely because the cost or value of the proposed project does not exceed the financial thresholds of those subdivisions shall file a letter of intent with the commissioner, if the

cost or value is greater than $750,000.00 or, in the case of durable medical equipment, $500,000.00. Upon review, the commissioner may require the health care facility to obtain a certificate of need if, within 30 days of receiving the letter of intent, he or she finds that the proposed development:

(1) may be inconsistent with the health resource allocation plan;

(2) has the potential for significantly increasing utilization or rates; or

(3) may substantially change the type, scope, or volume of service.

(c) 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.

(2) The purchase, lease, or other comparable arrangement of a single piece of durable medical equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. 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 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 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed by the hospital within the previous three fiscal years.

(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.

(d) A hospital that proposes to develop a project described in subdivision (c)(1) or (c)(2) of this section which is exempt from the requirements of this subchapter solely because the cost or value of the proposed project does not exceed the financial thresholds of those subdivisions shall file a letter of intent with the commissioner, if the cost or value is greater than $1,500,000.00 or, in the case of durable medical equipment, $750,000.00. Upon review, the commissioner may require the health care facility to obtain a certificate of need if, within 30 days of receiving the letter of intent, he or she finds that the proposed development:

(1) may be inconsistent with the health resource allocation plan;

(2) has the potential for significantly increasing utilization or rates;

(3) may substantially change the type, scope, or volume of service; or

(4) has the potential to place an undue financial burden on the hospital's resources.

(e) 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 $20,000,000.00, 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, and any other planning services 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 $20,000,000.00 and therefore not subject to this subsection.

(f) 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.

(g) 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. 11. 18 V.S.A. § 9435 is amended to read:

§ 9435. EXCLUSIONS

(a) Excluded from this subchapter are offices of physicians, dentists, or other practitioners of the healing arts, meaning the physical places which are occupied by such providers on a regular basis in which such providers perform the range of diagnostic and treatment services usually performed by such providers on an outpatient basis.

~~(b) The provisions of subsection (a) of this section shall not apply to the purchase of diagnostic or therapeutic equipment which would be~~ unless they are subject to review under subdivision ~~(a)(3) of section 9434~~ 9434(a)(4) of this title.

(b) Excluded from this subchapter are community mental health centers supervised by the commissioner of developmental and mental health services under chapter 177 and 207 of this title, provided the commissioner of developmental and mental health services makes a written approval of the proposed health care project. The community mental health center shall submit a copy of the approval with a letter of intent to the commissioner.

(c) The provisions of subsection (a) of this section shall not apply to offices owned or operated by a hospital or its subsidiary, parent, or holding company, outpatient diagnostic or therapy programs, kidney disease treatment centers, ~~mental health agencies or centers,~~ independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, ambulatory surgical centers, and diagnostic imaging facilities and similar facilities owned or operated by a physician, dentist, or other practitioner of the healing arts.

Sec. 12. REPEAL

Section 9436 of Title 18 (general criteria for granting a certificate of need) is repealed.

Sec. 13. 18 V.S.A. § 9437 is amended to read:

§ 9437. ~~REQUIRED FINDINGS~~ CRITERIA

~~In addition to the provisions of section 9436 of this title, with regard to any proposed new institutional health service for the provision of health services, the commissioner shall not grant a~~

~~certificate of need, or otherwise find that such proposed new institutional health services are needed, unless the commissioner finds that:~~

~~(1) superior alternatives to such services, in terms of cost, efficiency, and appropriateness, do not exist, and the development of such alternatives is not practicable;~~

~~(2) 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;~~

~~(3) in the absence of the proposed new service, patients would experience serious problems in terms of costs, availability, or, or such other difficulties as may be identified by the commissioner, in obtaining care of the type proposed;~~

~~(4) in the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care, the number of beds to be approved is not inconsistent with the considerations identified under section 9439(e) of this title; and~~

~~(5) The proposed new institutional health service is consistent with the certificate of need guidelines published by the department in accordance with its rules, and is within the portion of the unified health care budget, applicable to the proposed health care facility.~~

A certificate of need shall be granted if the applicant demonstrates and the commissioner finds that:

(1) the application is consistent with the health resource allocation plan;

(2) the cost of the project is reasonable, because:

(A) the applicant's financial condition will sustain any financial burden likely to result from completion of the project;

(B) the project will not result in an undue increase in the costs of medical care; and

(C) less expensive alternatives do not exist, would be unsatisfactory, or are not feasible or appropriate;

(3) there is an identifiable, existing, or reasonably anticipated need for the proposed project which is appropriate for the applicant to provide;

(4) the project will improve the quality of health care in the state or provide greater access to health care for Vermont's residents, or both;

(5) the project will not have an undue adverse impact on any other existing services provided by the applicant; and

(6) the project will serve the public good.

Sec. 14. 18 V.S.A. § 9439(f) is added to read:

(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. 15. 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:

~~(1)~~(A) institutional utilization data, including an explanation of the unique character of services and a description of case mix;

~~(2)~~(B) a population based description of the institution's service area;

~~(3)~~(C) the applicant's financial statements;

~~(4)~~(D) third party reimbursement data;

~~(5)~~(E) copies of feasibility studies, surveys, designs, plans, working drawings, or specifications developed in relation to the proposed project;

~~(6)~~(F) annual reports and ~~three-year long-range~~ four-year long range plans; ~~and~~

(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

~~(7)~~(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.

~~(b)~~(c) The application process shall be as follows:

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

~~(1)~~(2) Prior to filing an application for a certificate of need, an applicant shall file a 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. 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.

~~(2)~~(3) ~~Upon a determination by~~ The commissioner shall review each letter of intent and, 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) The commissioner, upon making an interim determination on the basis of a letter of intent that a project will be uncontested, may accept a preliminary application immediately upon making such a determination and issue proper public notice. If no interested party comes forth, the commissioner may then formally declare the application uncontested and may issue a certificate of need without further process or may declare, on its own motion, that the application is contested.~~

(4) Within 15 days or, in the case of review cycle applications under section 9439 of this title, within 30 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 additional information is required.

(5) 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. 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.

(6) 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~~, adversely~~ and directly affected by the new ~~institutional health service~~ health care project under review ~~or that they will materially assist~~. 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.

(7) 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 ~~institutional health service~~ 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.

(8) The health care ombudsman's office established under section 4089j 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.

~~(c)~~(d) The review process shall be as follows:

(1) The public oversight commission shall review:

(A) ~~the~~ The application materials provided by the applicant ~~and the arguments raised in favor of or against the proposal, if any, and may request the technical panel's advice, recommendations and comments on the merits of the application~~.

(B) The assessment of the applicant's materials provided by the department.

(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 ~~if requested by persons directly affected by the 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 (b)(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 ~~all applicants~~ the applicant and all other applicants in the case of a review cycle process.

~~(4)~~(5) After reviewing each application and after considering the recommendations of the public oversight commission, the commissioner shall make a decision either to issue ~~a certificate of need~~ or to deny the application for a certificate of need. ~~Notice of the decision shall be sent to the applicant. This notice shall state the basis of the decision.~~ 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. This notice shall make 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.

(d) The commissioner shall adopt rules governing procedures for the expeditious processing of applications ~~including those regarding expenditures~~ for replacement, repair, rebuilding, or re-

equipping 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.

(e) Any ~~party~~ 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.

Sec. 16. 18 V.S.A. § 9440a is added to read:

§ 9440a. APPLICATIONS, INFORMATION, AND TESTIMONY; OATH REQUIRED

(a) Each application filed under this subchapter, any written information required or permitted to be submitted in connection with an application or with the monitoring of an order, decision, or certificate issued by the commissioner, and any testimony taken before the public oversight commission, the commissioner, or a hearing officer appointed by the commissioner shall be submitted or taken under oath. The form and manner of the submission shall be prescribed by the commissioner. The authority granted to the commissioner under this section is in addition to any other authority granted to the commissioner under law.

(b) Each application shall be filed by the applicant's chief executive officer under oath, as provided by subsection (a) of this section. The commissioner may direct that information submitted with the application be submitted under oath by persons with personal knowledge of such information.

(c) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner or the public oversight commission or a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner or the public oversight commission or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in section 2901 of Title 13.

Sec. 17. 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, 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. 18. 18 V.S.A. § 9442 is amended to read:

§ 9442. ~~RECOMMENDATION AND DECISION REGARDING CERTIFICATE OF NEED; ISSUANCE OF CERTIFICATE OF NEED~~ BONDS

~~Upon completion of its review, the commissioner shall render a final decision on the application, based solely upon the criteria which were duly adopted and published at least 90 days prior to the submission of the original application under review, the evidence introduced into the record, and facts which have been officially noticed. The decision shall be in the form of an approval in whole or in part, or a denial. In granting a partial approval the commissioner shall not mandate any new institutional health service not proposed by the applicant or mandate the deletion of any existing service. Any partial approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application. In the case of a final decision to approve, in whole or in part, an application regarding a proposed new institutional health service, the commissioner shall issue a certificate of need to the applicant. The commissioner shall make a decision either to approve or deny within the time period specified for the review.~~

In any circumstance in which bonds are to be or may be issued in connection with a new health care project subject to the provisions of this subchapter, the certificate of need shall include the requirement that all information required to be provided to the bonding agency shall be provided also to the commissioner within a reasonable period of time. The commissioner shall be authorized to obtain any information from the bonding agency deemed necessary to carry out the duties of monitoring and oversight of a certificate of need. The bonding agency shall consider the recommendations of the commissioner in connection with any such proposed authorization.

Sec. 19. 18 V.S.A. § 9445 is amended to read:

§ 9445. ENFORCEMENT

(a) Any person who offers or develops any new ~~institutional health service~~ health care project within the meaning of this subchapter without first obtaining a certificate of need as required herein, or who otherwise violates any of the provisions of this subchapter, shall be subject to the following sanctions:

(1) The state shall not issue a license to any health care facility to operate, offer, or develop any new ~~institutional health service~~ health care project in violation of this subchapter and without a certificate of need or certificate of exemption issued pursuant thereto.

(2) The state shall not furnish from any reimbursement program administered by the state, nor shall any entity chartered under the laws of this state or any person doing business in the state provide reimbursement for any new ~~institutional health service~~ health care project offered or developed in contravention of the requirements of this subchapter.

(3) In addition to all other sanctions, if any person offers or develops any new ~~institutional health service~~ health care project without first having been issued a certificate of need or certificate of exemption therefore, or violates any other provision of this subchapter or any lawful rule or regulation promulgated thereunder, the commissioner and health care providers or

consumers located in the state shall have standing to maintain a civil action in the superior court of the county wherein such alleged violation has occurred, or wherein such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the commissioner, it shall be the duty of the attorney general of the state to furnish appropriate legal services and to prosecute an action for injunctive relief to an appropriate conclusion, which shall not be reimbursed under subdivision (2) of this subsection.

(b) ~~Any person who violates this subchapter or rules adopted hereunder shall be subject to a fine of not less than $1,000.00 nor more than $10,000.00 for each violation which shall not be reimbursed under subdivision (2) of subsection (a) of this section.~~ After notice and an opportunity for hearing, the commissioner may impose on a person who knowingly violates a provision of this subchapter, or a rule or order adopted pursuant to this subchapter or section 15 of Title 8, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the health care facility, whichever is greater, which shall not be reimbursed under subdivision (a)(2) of this section. A person aggrieved by a decision of the commissioner under this subdivision may appeal the commissioner's decision to the supreme court.

* * * Bonds * * *

Sec. 20. 16 V.S.A. § 3856(j) is added to read:

(j) In the case of bonds issued in connection with a new health care project subject to the provisions of subchapter 5 of chapter 221 of Title 18, the agency shall not authorize bonds on behalf of an eligible institution defined under subdivision 3851(c)(5) of this title, unless the project and the capital expenditures associated with the project have been approved by the commissioner of banking, insurance, securities, and health care administration, pursuant to subchapter 5 of chapter 221 of Title 18. The agency shall consider the recommendations of the commissioner in connection with any such proposed authorization.

* * * Charges for Examinations * * *

Sec. 21. 8 V.S.A. § 18 is amended to read:

§ 18. CHARGES FOR EXAMINATIONS, APPLICATIONS, REVIEWS AND INVESTIGATIONS

Every person subject to regulation by the department shall pay the department the reasonable costs of any examination, review, or investigation that is conducted or caused to be conducted by the department of such person, or of any application or filing made by such person, or of any examination, review, or investigation of any order, decision, or certificate issued by the commissioner, at a rate to be determined by the commissioner. The department may retain experts or other persons who are independently practicing their professions to assist in such examination, review, or investigation. The department shall be reimbursed for all reasonable costs and expenses, including the reasonable costs and expenses of such persons retained by the department, by the person examined, submitting the application or filing reviewed ~~or~~ , investigated, or subject to or under the jurisdiction of an order, decision, or certificate issued by the commissioner under this title or under Title 18. ~~A~~ An examination, review, or investigation subject to this section shall include, but not be limited to, ~~a~~ an examination, review, or investigation of any application, information, rate filing, or form filing submitted, or any order, decision, or certificate issued under this title, or under Title 18. In unusual circumstances, the commissioner may waive reimbursement for the costs and expenses of any review in the interests

of justice. Those institutions subject to assessment or fees for services provided under section 19 of this title shall not be billed for a regular examination performed under subsection 11501(a) of this title or for services for which such fees under subsection 19(a) of this title have been paid. The authority granted to the commissioner by this section is in addition to any other authority granted to the commissioner by law.

* * * Hospital Budget Reviews * * *

Sec. 22. 18 V.S.A. § 9453 is amended to read:

§ 9453. POWERS AND DUTIES

(a) ~~With the advice and recommendations of the technical panel, the~~ The commissioner shall:

(1) adopt uniform formats that hospitals shall use to report financial, scope-of-services, and utilization data and information;

(2) designate a data organization with which hospitals shall file financial, scope-of-services, and utilization data and information; and

(3) designate a data organization or organizations to process, analyze, store, or retrieve data or information.

(b) To effectuate the purposes of this subchapter the commissioner may adopt rules under chapter 25 of Title 3.

Sec. 23. 18 V.S.A. § 9454 is amended to read:

§ 9454. HOSPITALS; DUTIES

(a) Hospitals shall file the following information at the time and place and in the manner established by the commissioner:

(1) a budget for the forthcoming fiscal year;

(2) financial information, including but not limited to costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of services, and wage and salary data;

(3) scope-of-service and volume-of-service information, including but not limited to inpatient services, outpatient services, and ancillary services by type of service provided;

(4) utilization information;

(5) new hospital services and programs proposed for the forthcoming fiscal year;

(6) ~~a projected three-year capital expenditure budget~~ known depreciation schedules on existing buildings, a four-year capital expenditure projection, and a one-year capital expenditure plan; and

(7) such other information as the commissioner may require.

(b) Hospitals shall adopt a fiscal year which shall begin on October 1.

Sec. 24. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The commissioner shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter, and in accordance ~~to~~ with a schedule established by the commissioner.

(b) In conjunction with budget reviews, the commissioner shall:

(1) review utilization information;

(2) consider the goals and recommendations of the ~~health resource management plan or state health plan, whichever applies~~ health resource allocation plan;

(3) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

(4) consider any reports from professional review organizations;

(5) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

(6) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

(7) give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets;

(8) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;

(9) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid reimbursements resulting from appropriations designed to reduce the Medicaid cost shift~~; and~~

~~(10) seek the advice and recommendations of the public oversight commission~~.

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

(1) be consistent with the health resource ~~management~~ allocation plan ~~or state health plan, whichever applies~~;

(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)(10) of this section is a reasonable methodology for reflecting a reduction in net revenues for non-Medicaid payers.

(d) ~~Beginning October 1, 1996, and annually thereafter~~ Annually, the commissioner shall ~~consider the recommendations of the public oversight commission and~~ establish a budget for each hospital by September 15 followed by a written decision by October 1. Each hospital shall operate within the budget established under this section.

(e) The commissioner may establish, by rule, a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. The rule ~~may~~ shall permit the commissioner to waive one or more of the review processes listed in subsection (b) of this section, but not for more than ~~one year~~ two years consecutively. Tertiary teaching hospitals shall not be eligible for a waiver.

(f) The commissioner may, upon application, adjust a budget established under this section upon a showing of need based upon exceptional or unforeseen circumstances in accordance with the criteria and processes established under section ~~9406~~ 9405 of this title.

(g) The commissioner may request, and a hospital shall provide, information determined by the commissioner to be necessary to determine whether the hospital is operating within a budget established under this section.

(h)(1) If a hospital violates a provision of this section, the commissioner may maintain an action in the superior court of the county in which the hospital is located to enjoin, restrain or prevent such violation.

(2) After notice and an opportunity for hearing, the commissioner may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this

subchapter, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(3)(A) The commissioner shall require the officers and directors of a hospital to file under oath, on a form and in a manner prescribed by the commissioner, any information designated by the commissioner and required pursuant to this subchapter. The authority granted to the commissioner under this subsection is in addition to any other authority granted to the commissioner under law.

(B) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner or to the public oversight commission or to a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner or the public oversight commission or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in section 2901 of Title 13.

* * * Report on Hospital Collaboration * * *

Sec. 25. REPORT ON COLLABORATION AMONG HOSPITALS

The commissioner of banking, insurance, securities, and health care administration shall invite Fletcher Allen Health Care and the Dartmouth Hitchcock Medical Center to identify fields of excellence or discrete areas of specialty focus for the respective health care institutions, and to make recommendations for collaboration. The commissioner shall report to the general assembly on or before December 15, 2003 and annually thereafter on the progress of the collaboration.

Sec. 26. STATUTORY REVISION

(a) In chapter 221 of Title 18, all references to the "technical panel" shall be stricken.

(b) In chapter 221 of Title 18, the phrase "institutional health service" shall be replaced with the phrase "health care project."

Sec. 27. EFFECTIVE DATE

This act shall take effect on July 1, 2003, except that:

(1) Secs. 6, 7, and 22 through 24 shall apply to hospital budget reviews for fiscal years 2005 and thereafter.

(2) Secs. 17 and 21 shall take effect on passage and shall apply to the certificate of need applications pending on or before the date of passage.

(3) Secs. 12 and 13 shall take effect on July 1, 2005 or upon adoption by the governor of the health resource allocation plan, whichever occurs first.

(4) Except for Secs. 17 and 21, this act shall not apply to certificate of need applications filed before July 1, 2003.

Approved: June 4, 2003