

No. 1992-179

## AN ACT

HB 1982

Amending the act of July 19, 1979 (P.L.130, No.48), entitled "An act relating to health care; prescribing the powers and duties of the Department of Health; establishing and providing the powers and duties of the State Health Coordinating Council, health systems agencies and Health Care Policy Board in the Department of Health, and State Health Facility Hearing Board in the Department of Justice; providing for certification of need of health care providers and prescribing penalties," abolishing the State Health Coordinating Council and the Health Care Policy Board; further providing for health planning; establishing the Health Policy Board; and making repeals.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Sections 103, 201 and 202 of the act of July 19, 1979 (P.L.130, No.48), known as the Health Care Facilities Act, amended or added July 12, 1980 (P.L.655, No.136), are amended to read:

Section 103. Definitions.

The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Act." The comprehensive Health Care Facilities Act.

"Affected person." A person whose proposal is being reviewed for purposes of certificate of need, the health systems agency for the health service area in which the proposed new institutional health service is to be offered or developed, health systems agencies serving contiguous health service areas, health care facilities and health maintenance organizations located in the health service area which provide institutional health services, and those members of the public who are to be served by the proposed new institutional health services and those agencies, if any, which establish rates for health care facilities and health maintenance organizations located in the health systems area in which the proposed new institutional health service is to be offered or developed.

"Annual implementation plan." The latest health systems agency's annual statement of objectives to achieve the goals of the health systems plan, including the priorities established among the objectives.]

"Board." *The Health Policy Board established under section 401.1.*

"Certificate of need." A [certificate] *notice of approval* issued by the department under the provisions of this act, including those *notices of approval* issued as an amendment to an existing certificate of need.

"Clinically related health service." *Certain diagnostic, treatment or rehabilitative services as determined in section 701.*

"Community-based health services planning committee." *A committee established in accordance with procedures approved by the Department of*

*Health which includes representatives of local or regional groups of consumers, business, labor, health care providers, payors or other affected interests.*

“Conflict of interest.” For the purpose of section 501, the interest of any person, whether financial, by association with, or as a contributor of money or time to, any nonprofit corporation or other corporation, partnership, association, or other organization, and whenever a person is a director, officer or employee of such organization, but shall not exist whenever the organization in which such person is interested is being considered as part of a class or group for whom regulations are being considered, if the material facts as to the relationship or interest are disclosed or are known to the board.

“Consumer.” A natural person [who is not a “provider of health care” as defined in Title XV of the Federal Public Health Service Act] *who is not involved in the provision of health services or health insurance.* For the purpose of [section 301] *this act*, any person who holds a fiduciary position in any health care facility [or], health maintenance organization *or third party payor* shall not be considered a consumer.

“Department.” The Department of Health.

“Develop.” When used in connection with health services or facilities, means to undertake those activities which on their completion will result in the offer of a new health service or the incurring of a financial obligation in relation to the offering of such a service.

“Health care facility.” **A general or special hospital including tuberculosis and psychiatric hospitals, rehabilitation facilities skilled nursing facilities, kidney disease treatment centers including free-standing hemodialysis units, intermediate care facilities and ambulatory surgical facilities, both profit and nonprofit and including those operated by an agency of State or local government, but shall not include an office used exclusively for their private or group practice by physicians or dentists, nor a program which renders treatment or care for drug or alcohol abuse or dependence, unless located within, by or through a health care facility, a facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination, nor a facility conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other persons in a religious profession who are members of the religious denominations conducting the facility.**

This definition shall exclude all health care facilities as hereinabove defined that do not accept, directly or indirectly, any Federal or State Governmental funds for capitalization, depreciation, interest, research or reimbursement, unless the Secretary of Health, Education and Welfare, pursuant to Federal Public Law 93-641, section 1523(a)(4)(B), concludes that this exclusionary provision is unsatisfactory to the Departments of Health, Education and Welfare.

“Health maintenance organization.” **An organization defined as a health maintenance organization by section 1531(8) of the Federal Public Health Service Act or an organization regulated by the act of December 29, 1972 (P.L.1701, No.364), known as the “Voluntary Nonprofit Health Service Act of 1972.”]**

**“Health care facility.”** For purposes of Chapter 7, any health care facility providing clinically related health services, including, but not limited to, a general or special hospital, including psychiatric hospitals, rehabilitation hospitals, ambulatory surgical facilities, long-term care nursing facilities, cancer treatment centers using radiation therapy on an ambulatory basis and inpatient drug and alcohol treatment facilities, both profit and nonprofit and including those operated by an agency or State or local government. The term shall not include an office used primarily for the private or group practice by health care practitioners where no reviewable clinically related health service is offered, a facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination or a facility conducted by a religious organization for the purpose of providing health care services exclusively to clergy or other persons in a religious profession who are members of the religious denominations conducting the facility.

**“Health care practitioner.”** An individual who is authorized to practice some component of the healing arts by a license, permit, certificate or registration issued by a Commonwealth licensing agency or board.

**“Health care provider” or “provider.”** An individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), the Commonwealth, or a political subdivision or instrumentality (including a municipal corporation or authority) thereof, that operates a health care facility.

**“Health [service] planning area.”** [The area served by a health systems agency as designated in accordance with Title XV of the Federal Public Health Service Act.] A geographic area within the Commonwealth designated by the Department of Health for purposes of health planning.

**["Health services.”** Clinically related (i.e., diagnostic, treatment or rehabilitative) services, including alcohol, drug abuse and mental health services.

**“Health systems agency” or “HSA.”** An entity which has been conditionally or fully designated pursuant to Title XV of the Federal Public Health Service Act.]

**“Hearing board.”** The State Health Facility Hearing Board created in the [Department of Justice] Office of General Counsel under the provisions of this act.

**["Home health care.”** The provision of nursing and other therapeutic services to disabled, injured or sick persons in their place of residence and other health related services provided to protect and maintain persons in their own home.

**“Major medical equipment.”** Medical equipment which is used for the provision of medical and other health services and which costs in excess of \$150,000, except major medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician’s office and a hospital and it has been determined under the Medicare program to meet the applicable requirements of section 1861(s) of the Federal Social Security Act. In determining whether

medical equipment has a value in excess of \$150,000, the value of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition of such equipment shall be included.]

**“Interested person” or “person expressing an interest.”** For the purposes of Chapter 7, a member of the public who is to be served by the proposed new health service in the area to be served by the applicant, a health care facility or health maintenance organization or any health-care provider providing similar services in the area to be served by the applicant or who has received a certificate of need to provide services in the area to be served by the applicant or who has formally filed with the department a letter of intent to provide similar services in the area in which the proposed service is to be offered or developed and any third party payor of health services provided in that area who provides written notice to the department that the person is interested in a specific certificate of need application before the department.

**“Offer.”** Make provision for providing in a regular manner and on an organized basis [specified] *clinically related* health services.

**“Patient.”** A natural person receiving health care in or from a health care provider.

**“Person.”** A natural person, corporation (including associations, joint stock companies and insurance companies), partnership, trust, estate, association, the Commonwealth, and any local governmental unit, authority and agency thereof. [The term shall include all entities owning or operating a health care facility or health maintenance organization.]

**“Persons directly affected.”** A person whose proposal for certificate of need is being reviewed, members of the public who are to be served by the proposed new institutional health services, health care facilities and health maintenance organizations located in the health service area in which the service is proposed to be offered or developed which provide services similar to the proposed services under review, and health care facilities and health maintenance organizations which prior to receipt by the agency of the proposal being reviewed have formally indicated an intention to provide such similar service in the future and those agencies, if any, which establish rates for health care facilities and health maintenance organizations located in the health systems area in which the proposed new institutional health service is to be offered or developed.]

**“Policy board.”** The [Health Care Policy Board] *Health Policy Board* created in the Department of Health under the provisions of this act.

**“Predevelopment costs.”** Expenditures for preparation of architectural designs, working drawings, plans and specifications.]

**“Public [hearing] meeting.”** A meeting open to the public where any person has an opportunity to [present testimony held without imposition of a fee] *comment on a certificate of need application or proposed State health services plan amendment.*

**“Rehabilitation facility.”** An inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.]

“Secretary.” The Secretary of the Department of Health of the Commonwealth of Pennsylvania.

["Statewide Health Coordinating Council" or "SHCC", or "council." The council established in compliance with Title XV of the Federal Public Health Service Act.]

*"State health services plan."* A document developed by the Department of Health, after consultation with the policy board and approved by the Governor, that is consistent with section 401.3, that meets the current and projected needs of the Commonwealth's citizens. The State health services plan shall contain, in part, the standards and criteria against which certificate of need applications are reviewed and upon which decisions are based.

"Third party payor." A person who makes payments on behalf of patients under compulsion of law or contract who does not supply care or services as a health care provider or who is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits[, but]. *The term* shall not include the Federal, State, or any local government unit, authority, or agency thereof or a health maintenance organization.

Section 201. Powers and duties of the department.

The Department of Health shall have the power and its duties shall be:

**[(1) To act as a single State agency through its staff and the policy board in serving as the designated sole State health planning and development agency in accordance with Titles XV and XVI of the Federal Public Health Service Act.**

**(2)] (1) To exercise exclusive jurisdiction over health care providers[, and jurisdiction over health maintenance organizations] in accordance with the provisions of this act.**

**(2) To issue determinations of reviewability or nonreviewability of certificate of need proposals.**

**(3) To issue certificates of need and amended certificates of need in accordance with the provisions of this act.**

**(4) [With respect to health care facilities, to investigate, and report to the Auditor General, upon every application to the Auditor General made by any institution, corporation or unincorporated association, desiring to give a mortgage under the provisions of the act of April 29, 1915 (P.L.201, No.112), entitled "An act making mortgages, given by benevolent, charitable, philanthropic, educational and eleemosynary institutions, corporations, or unincorporated associations, for permanent improvements and refunding purposes, prior liens to the liens of the Commonwealth for the appropriation of moneys; providing a method for the giving of such mortgages and fixing the duties of the Auditor General and Board of Public Charities in connection therewith.]" To withdraw expired certificates of need.**

**[(5) To evaluate at least annually its functions and performance and their economic effectiveness.**

**(6) To prepare, in accordance with applicable Federal law, an inventory of the health care facilities located in the Commonwealth and evalu-**

ate on an on-going basis the physical condition of such facilities. The inventory and evaluation shall be periodically reported to every HSA.

(7) (5) To require, pursuant to regulation, submission of periodic reports by providers of health services and other persons subject to review respecting the development of proposals subject to review.

[(8) To research, prepare and after approval by the SHCC and the Governor publish triennially a State health plan for the Commonwealth based on the various health systems plans.

(9) To provide coordination with the National Center for Health Statistics of the activities of the department for the collection, retrieval, analysis, reporting and publication of statistical and other information relating to health and health care and to require health care providers doing business in the Commonwealth to make statistical and other reports of information required by Federal law to be submitted to the National Center for Health Care Statistics; and to collect such other information as may be appropriate to determine the appropriate level of facilities and services for the effective implementation of certification of need under this act.

(10) To furnish such staff support and expertise to the department's policy board as may be needed by them to perform their responsibilities provided that any refusal of a substantial request from such board be subject to final determination by the Governor.]

*(6) Upon consultation with the policy board, to research, prepare and, after approval by the Governor, publish, no later than 18 months after the effective date of this act and annually thereafter, a revised State health services plan for the Commonwealth as defined under this act. Until the State health services plan as defined in section 401.3 is adopted, the department shall apply the State health plan in existence on the effective date of this act, along with any subsequent updates to that plan.*

*(7) To collect and disseminate such other information as may be appropriate to determine the appropriate level of facilities and services for the effective implementation of certification of need under this act. Where such information is collected by any other agency of State government, duplication shall be avoided by coordination of data collection activities.*

*(8) To furnish such staff support and expertise to the policy board as may be needed to perform its responsibilities.*

[(11)] (9) To receive, [docket] log and review all applications for certificates of need or amendments thereof and approve or disapprove the same.

[(12) To determine the Statewide health needs of the Commonwealth after providing reasonable opportunity for the submission of written recommendations respecting such needs by State agencies responsible for planning with regard to mental health, mental retardation and other developmental disabilities, and drug and alcohol abuse, as well as other agencies of State Government designated by the Governor for the purpose of making such recommendations and after consulting with SHCC.

(13) (10) To minimize the administrative burden on health care providers by eliminating unnecessary duplication of financial and operational

reports and to the extent possible coordinating reviews and inspections performed by Federal, State, local and private agencies.

**[(14)] (11)** To adopt and promulgate~~], after consultation with the policy board,~~ regulations necessary to carry out the purposes and provisions of this act relating to certificate of need.

**[(15)] (12)** To enforce the rules and regulations promulgated by the department as provided in this act.

**[(16)** To consult with the SHCC in the administration of this act.

**(17)] (13)** To provide technical assistance to individuals and public and private entities in filling out the necessary forms for the development of projects and programs.

**(14)** *To establish and publish in the Pennsylvania Bulletin a fee schedule for certificate of need applications and letters of intent in accordance with section 902.1.*

**(15)** *To coordinate any data collection activities necessary for administration of this act so as not to duplicate unnecessarily the data-collection activities of other Federal and State agencies.*

**(16)** *To modify the list of reviewable clinically related health services established under section 701.*

Section 202. Encouragement of competition and innovation.

The ~~health systems agencies and the~~ department shall in ~~their~~ *its* planning and review activities foster competition ~~and~~ *to promote cost efficiency, quality and access to care. The department shall encourage cooperative health care arrangements which focus on the health care needs of a health planning area and foster the prudent and economical control of the area's resources. The department shall also* encourage innovations in the financing and delivery systems for *clinically related* health services that will promote economic behavior by consumers and providers of *clinically related* health services ~~and~~ that ~~lead~~ *leads* to appropriate investment *in*, supply and use of health services. ~~To this end, the health systems plan and the annual implementation plan adopted by the health systems agencies and State health plan shall include an assessment of the current and potential scope of competition and market forces to establish appropriate investment and utilization patterns in the Commonwealth and shall specify the public and private actions needed to strengthen these forces. Revisions of the plan shall assess individual services or types of providers as to whether the conditions for competition have improved in the period since the last plan.]~~

Section 2. Sections 301, 302, 303 and 401 of the act are repealed.

Section 3. The act is amended by adding sections to read:

**Section 401.1. Health Policy Board.**

**(a)** *An advisory board is hereby established in the department known as the Health Policy Board. The membership of the board shall consist of:*

- (1)** *The Secretary of Health or his designee who shall act as chairman.*
- (2)** *One representative of hospitals.*
- (3)** *One physician.*
- (4)** *One representative of a long-term care facility.*

(5) *Two health care providers not already designated, one of whom shall be a provider of home health services.*

(6) *One representative of Blue Cross or Blue Shield.*

(7) *One representative of health maintenance organizations.*

(8) *One representative of commercial insurance carriers.*

(9) *One representative of business.*

(10) *One representative of organized labor.*

(11) *Three consumers.*

(12) *One representative of county or municipal government.*

(b) *All members shall be appointed to the policy board by the Governor and confirmed by a majority vote of the Senate. The Governor shall make all appointments to the policy board within 90 days of the effective date of this act, and the operations of the policy board shall begin immediately upon confirmation of the full board. The secretary shall convene the first meeting within 30 days after the confirmation of the full board.*

(1) *Appointments shall be made in a manner that provides representation of the various geographical regions of this Commonwealth, including those medically underserved areas in rural and inner-city locations. At least two of the appointments shall be individuals knowledgeable of rural health care needs.*

(2) *Of the 15 members first appointed, five shall be appointed for a term of one year, five for a term of two years and five for a term of three years. Thereafter, appointments shall be made for a term of three years.*

(3) *No appointed member shall serve more than two full consecutive terms of three years.*

(4) *No policy board member, other than the secretary, may act or attend through a designee or a proxy.*

(c) *A simple majority of those members with current appointments of the policy board shall constitute a quorum for the transaction of any business. The act by the majority of the members present at any meeting in which there is a quorum shall be deemed to be an act of the board.*

(d) *All meetings of the policy board shall be advertised and conducted pursuant to the act of July 3, 1986 (P.L.388, No.84), known as the "Sunshine Act." The board shall meet at least four times a year and may provide for special meetings as may be necessary.*

(e) *The members of the policy board shall not receive any compensation for serving as members of the board but shall be reimbursed at established Commonwealth rates for necessary expenses incurred in the performance of their duties.*

#### **Section 401.2. Powers and duties of policy board.**

*The policy board shall exercise all powers necessary and appropriate to carry out its duties, including the following:*

(1) *Advise and assist the department in development and revision of the State health services plan.*

(2) *Annually review a work plan developed by the department which identifies those provisions of the State health services plan which must be revised, reconsidered or developed within the succeeding calendar year.*



(3) *Annually review the list of clinically related health services subject to review developed by the department pursuant to the provisions of section 701.*

**Section 401.3. State health services plan.**

*The State health services plan shall consist of at a minimum:*

(1) *An identification of the clinically related health services necessary to serve the health needs of the population of this Commonwealth, including those medically underserved areas in rural and inner-city locations.*

(2) *An analysis of the availability, accessibility and affordability of the clinically related health services necessary to meet the health needs of the population of this Commonwealth.*

(3) *Qualitative and quantitative standards and criteria for the review of certificate of need applications by the department under this act.*

(4) *An exceptions process which permits exceptions to be granted to the standards and criteria in order to reflect local experience or ensure access or to respond to circumstances which pose a threat to public health and safety.*

Section 4. Sections 402, 403, 404 and 405 of the act are repealed.

Section 5. Section 501 of the act is amended to read:

**Section 501. State Health Facility Hearing Board.**

There is hereby created the State Health Facility Hearing Board in the [Department of Justice] *Office of General Counsel* which shall consist of [three] *five* members who shall initially be appointed for terms of one, two and three years respectively by the Governor and confirmed by a majority vote of the Senate. Thereafter, appointments shall be by the Governor for four year terms and confirmed by a majority vote of the Senate. Members shall be chosen for their familiarity and experience with health care facilities or for relevant training and experience which will assist the board to perform its functions. *Appointments shall be made to ensure that at least one of the members shall be a member of the bar of the Supreme Court of Pennsylvania.* No person shall be chosen who is at the time of appointment an employee of the Commonwealth or of any health care provider. No member shall participate in any action or decision concerning any matter in which the member has an economic interest or other conflict of interest.

Section 6. Section 502 of the act, amended July 12, 1980 (P.L.655, No.136), is amended to read:

**Section 502. Powers and duties of the hearing board.**

(a) The hearing board shall have the powers and its duties shall be:

(1) To hear appeals *by the applicant or interested persons* from departmental decisions on applications for certificates of need or amendments thereto *and from determinations of reviewability.*

(2) To hear upon petition objections to published regulations, criteria, or standards of the [health systems agency or] department as to the policies therein set forth and where appropriate to request the promulgating agency to reconsider such policies *set forth in this chapter for certificate of need.*

**[(3) To hear appeals from decisions of the department which require a person to obtain a certificate of need for major medical equipment or the acquisition of an existing health care facility.**

**(4)] (3) To fix the place of hearings in the area from which the application arises in matters relating to certificate of need.**

**(b) Hearings may be held before one or more members of the board, but action of the board shall be made by majority vote of the board.**

**Section 7. Section 503 of the act is amended to read:**

**Section 503. Counsel.**

**The [Attorney General] Office of General Counsel shall appoint counsel to serve and advise the hearing board and shall replace such counsel upon request of the board.**

**Section 8. Section 505 of the act, amended July 12, 1980 (P.L.655, No.136), is amended to read:**

**Section 505. Hearings before the hearing board.**

**(a) All hearings before the hearing board shall be subject to right of notice, hearing and adjudication in accordance with 2 Pa.C.S. Chaps. 5 and 7, known as the Administrative Agency Law, and a written record shall be kept of said proceedings and a copy thereof provided to the parties at cost.**

**(b) Persons conducting hearings under this act shall have the power to subpoena witnesses and documents required for the hearing, to administer oaths and examine witnesses and receive evidence in any locality which the hearing body may designate, having regard to the public convenience and proper discharge of its functions and duties.**

**(c) Notice of hearings before the hearing board shall be given to the parties at least 21 days in advance of the hearing. In appeals to the board from the decision of the department on an application for certificate of need or amendment thereof, notice of the same shall be published in a newspaper in general circulation in the [health service area and to the] areas ~~[affected]~~ *where the service is proposed* and in the Pennsylvania Bulletin at least 14 days before the hearing.**

**(d) *The hearing board shall have the authority to adopt rules and regulations establishing procedures for the taking of appeals and other procedural rules and regulations as it deems advisable as provided in section ~~691.~~***

**Section 9. Section 506 of the act is amended to read:**

**Section 506. Appeals to the hearing board.**

**[(a) Decisions of the department on an application for a certificate of need or amendment thereto may be appealed within 30 days by any party or health systems agency who is involved in the proceeding. The appeal to the hearing board shall be commenced within 30 days of the appeal and shall be limited to issues raised by the appellant in the specification of objections to the decision of the department which shall raise no further issues not brought to the attention of the health systems agency or the department, and the board shall entertain no evidence that the hearing board is satisfied the appellant was able, by the exercise of reasonable diligence, to have submitted before the health systems agency and the department.]**

*(a) A decision of the department on an application for a certificate of need or amendment thereto or a determination of reviewability may be appealed within 30 days of the mailing date of the decision by the applicant or by any interested person who requested a public meeting on the application and participated in the public meeting or can fully document and make available material information which is relevant to the review and which was not available during the period when the department completed its review. The appeal to the hearing board shall be commenced within 30 days of the filing of the notice of appeal. The appellant shall raise no issues not brought to the attention of the department during its review, and the board shall neither hear nor receive evidence unless it is satisfied the appellant was unable to submit such evidence before the department. For purposes of this subsection, an appeal shall be deemed to commence with the establishment by the board of a schedule for the filing of briefs by the parties to the appeal.*

*(b) [The] In reaching its decisions, the hearing board shall be bound by the duly promulgated regulations of the department and shall [give due deference to] recognize the expertise of [the health systems agencies and] the department [in reaching their decisions]. It shall receive any evidence as to challenges of the authority of the department or the reasonableness of the criteria or regulations used in the review of the application for the sole purpose of creating a record for any subsequent appeal to court.*

*[(c) When any decision of the hearing board is inconsistent with the recommendations made with respect thereto by a health systems agency, or with the applicable health systems plan or annual implementation plan, the hearing board shall submit to such health systems agency and all parties to the proceeding a written, detailed statement of the reasons for the inconsistency.]*

*(c) The hearing board shall submit to all parties to the proceeding a written, detailed statement which sets forth its decision and the reasoning upon which the decision is based.*

Section 10. Section 507 of the act, repealed in part October 5, 1980 (P.L.693, No.142), is amended to read:

Section 507. Appeals and procedures on appeals.

The action of the hearing board may be appealed by any party [or health systems agency] who is involved in [that proceeding] *the appeal before the board.*

Section 11. Section 601 of the act, amended July 12, 1980 (P.L.655, No.136) and repealed in part June 25, 1982 (P.L.633, No.181), is amended to read:

Section 601. Promulgation of rules and regulations.

*[(a) All rules and regulations under this act shall be prepared by the department and submitted for review by the policy board and the department shall consult with the policy board before proposed regulations are published.]*

*(b) All rules and regulations adopted under this act shall provide fair access and due process in all proceedings held to carry out the provisions of this act and shall not require an applicant to supply data or information as to other health care facilities or health maintenance organizations.*

(e) The department shall also publish a notice of the availability of proposed regulations relating to certificate of need and any revisions thereof in accordance with the designation agreement with the Secretary of Health, Education and Welfare, if any, in at least two newspapers in general circulation in the Commonwealth, together with a place they may be examined and copied by interested persons.

(f) Proposed regulations establishing certificate of need review procedures and criteria or changes therein shall be distributed by the department to the SHCC, each health systems agency operating in the Commonwealth and Statewide health agencies and organizations and those agencies, if any, which establish rates for health care facilities and health maintenance organizations.

(g) The department shall distribute copies of adopted final regulations on certificate of need review procedures and criteria, and any revisions thereof, to persons set forth in subsection (f) and to the Departments of Health, Education and Welfare and shall provide such copies to other interested persons upon request.

(h) Prior to review by the department of new institutional health services under this act, the department shall disseminate to all health care facilities and health maintenance organizations within the Commonwealth, and shall publish in one or more newspapers in general circulation within the Commonwealth a description of coverage of the certificate of need program for review, as determined under regulations, and any revisions thereof shall be similarly disseminated and published.]

*(a) The department in the exercise of its duties under this act shall have the power to adopt such regulations as are necessary to carry out the purposes of this act. Regulations shall be adopted in conformity with the provisions of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, and the act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."*

*(b) All rules and regulations adopted under this act shall provide fair access and due process in all proceedings held to carry out the provisions of this act and shall not require an applicant to supply data or information as to other health care facilities or health care providers.*

Section 12. Section 603 of the act, amended July 12, 1980 (P.L.655, No.136) and repealed in part October 5, 1980 (P.L.693, No.142) and December 20, 1982 (P.L.1409, No.326), is amended to read:

Section 603. Enforcement of orders relating to certificate of need.

(a) (1) No certificate of need shall be granted to any person for a [new institutional] health care facility or reviewable clinically related health service unless such [new institutional] facility or clinically related health service is found by the department to be needed.

(2) [Only those new institutional health services which are granted certificates of need shall be offered or developed within the Commonwealth by any person.] No person shall offer or develop a health care facility or reviewable clinically related health service without obtaining a certificate of need as required by this act.

(3) **[No expenditures in excess of \$150,000 in preparation for the offering or development of a new institutional health service shall be made by any person unless a certificate of need for such services or expenditures has been granted.]**

(4) **No binding arrangement or commitment for financing the offering or development of a [new institutional] *health care facility or reviewable clinically related* health service shall be made by any person unless a certificate of need for such [new institutional] *clinically related* health service or facility, or the preparation for the offering or development of the same] has been granted *in accordance with this act*.**

(b) Orders for which the time of appeal has expired shall be enforced by the department in summary proceedings or, when necessary, with the aid of the court.

(c) No collateral attack on any order, including questions relating to jurisdiction shall be permitted in the enforcement proceeding, but such relief may be sought when such relief has not been barred by the failure to take a timely appeal.

(d) Any person operating a [new institutional] *reviewable clinically related* health service or *health care facility* within this Commonwealth for which no certificate of need has been obtained, after service of a cease and desist order of the department, or after expiration of the time for appeal of any final order on appeal, upon conviction thereof, shall be sentenced to pay a fine of not less than \$100 or more than \$1,000 and costs of prosecution. Each day of operating a [new institutional] *clinically related* health service or *health care facility* after issuance of a cease and desist order shall constitute a separate offense.

(e) Any person [violating] *who violates* this act by [a willful failure] *failing* to obtain a certificate of need, [or willfully] *by* deviating from the provisions of the certificate, [or] *by* beginning construction, [or] *by* providing services, or *by* acquiring equipment after the expiration of a certificate of need shall be subject to a penalty of not less than \$100 per day and not more than \$1,000 per day. Each day [after notice to them of the existence] of *each* such violation shall be considered a separate offense.

(f) The department [shall] *may* seek injunctive relief to prevent continuing violations of this act. *In seeking such relief, the department need not prove irreparable harm.*

(g) No license to operate a health care facility, health maintenance organization, or new institutional] or *reviewable clinically related* health service by any person in this Commonwealth shall be granted and any license issued shall be void and of no effect as to any facility, organization, service or part thereof for which a certificate of need is required by this act and not granted.

[(h) No person shall acquire major medical equipment which will not be owned or operated in a health care facility or acquire an existing health care facility except in accordance with this act.]

Section 13. Section 701 of the act, amended July 12, 1980 (P.L.655, No.136), is amended to read:

Section 701. Certificate of need required; [new institutional] *clinically related* health services subject to review.

[(a) No person shall offer, develop, construct or otherwise establish or undertake to establish within the State a new institutional health service without first obtaining a certificate of need from the department. For purposes of this chapter, "new institutional health services" shall include:

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

(2) Any expenditure by or on behalf of a health care facility or health maintenance organization in excess of \$150,000 which, under generally accepted accounting principles consistently applied, is a capital expenditure. Expenditures for acquisitions of existing health care facilities and health maintenance organizations shall not be included unless the notice required by subsection (i) of section 702 is not filed or the department finds within 30 days of receipt of such notice that the services or bed capacity of the health care facility will be changed in being acquired. An acquisition by or on behalf of a health care facility or health maintenance organization under lease or comparable arrangement, or through donation, which would have required review if the acquisition had been by purchase, shall be deemed a capital expenditure subject to review.

(3) The obligation of any capital expenditure by or on behalf of a health care facility which results in the addition of a health service not provided in or through the facility in the previous 12 months or which increases the number of beds (or redistributes beds among various categories other than levels of care in a nursing home, or relocates such beds from one physical facility or site to another) by more than ten beds or more than 10% of total bed capacity, as defined by the regulations, whichever is less, over a two-year period.

(4) The addition of a health service which is offered in or through a health care facility having an operating expense in excess of the minimum annual operating expense established in accordance with Title XV of the Federal Public Health Service Act, and which were not offered on a regular basis in or through such health care facility or health maintenance organization within the 12-month period prior to the time such services would be offered.

(5) Major medical equipment not owned by or located in a health care facility which will:

- (i) be used to provide service for inpatients of a health care facility;
- or
- (ii) for which a notice was not provided in accordance with subsection (i) of section 702.

(b) (1) Any expenditure by or on behalf of health care facilities or a health maintenance organization in excess of \$150,000 made in preparation for the offering or development of a new institutional health service and any binding arrangement or commitment by either of them for financing the offering or development of the new institutional health service shall be subject to review under this chapter.

(2) Nothing in this paragraph shall preclude the department from granting a certificate of need which permits expenditures only for predevelopment activities, but does not authorize the offering or development of the new institutional health service with respect to which such predevelopment activities are proposed.

(c) Notwithstanding the provisions of subsection (a) or (b) a new institutional health service acquired, owned or operated by a health maintenance organization and home health care shall be subject to the provisions of this act only to the extent required by Federal law.

(d) As higher minimum expenditures requiring review are set by the Federal Government, those limits shall immediately apply in lieu of the minimum expenditure limits set by this act.]

(a) *Any person, including, but not limited to, a health care facility, health maintenance organization or health care provider who offers, develops, constructs, renovates, expands or otherwise establishes or undertakes to establish within the State a clinically related health service that is included in the department's list of reviewable services developed under subsections (d) and (e) or a health care facility as defined in section 103 must obtain a certificate of need from the department if one or more of the following factors applies:*

(1) *The proposal requires a capital expenditure in excess of \$2,000,000 under generally accepted accounting principles, consistently applied.*

(2) *The proposal involves the establishment of a health care facility or a reviewable clinically related health service.*

(3) *The proposal increases the number of licensed beds by more than ten beds or 10%, whichever is less, every two years.*

(i) *If the additional beds are acute care beds and are not beds in a distinct-part psychiatric, rehabilitation or long-term care unit, all licensed beds of the acute-care facility shall be counted in determining whether the increased number of beds exceeds 10%.*

(ii) *If the additional beds are beds in a distinct-part psychiatric, rehabilitation or long-term care unit of an acute care facility, only the beds within that unit shall be counted in determining whether the increased number of beds exceeds 10%.*

(iii) *If the additional beds are in a freestanding psychiatric, rehabilitation or long-term care facility, all licensed beds of the freestanding facility shall be counted in determining whether the increased number of beds exceeds 10%.*

(4) *The proposal substantially expands an existing clinically related health service as determined by the department in the State health services plan.*

(b) *For the purposes of this act, an expenditure for the purpose of acquiring an existing health care facility or replacement of equipment where there is no change in service shall not be considered to be a capital expenditure subject to review. Expenditures for nonclinical activities or services, such as parking garages, computer systems or refinancing of debt, and research projects involving premarket approval of new equipment shall not be subject to review.*

*(c) The capital expenditure threshold identified in subsection (a)(1) may be modified periodically by the department to reflect any increase in the construction cost or other factors influencing health care-related capital expenditures. The department shall publish a modification of the expenditure threshold through the regulatory review process.*

*(d) A list of reviewable clinically related health services shall be published by the department within 30 days of the effective date of this act and may be modified by regulation on an annual basis. Exclusive of new high-cost technology, the initial list published by the department as required under this subsection shall be no more extensive than those services reviewable on the effective date of this act. Criteria for inclusion of reviewable services shall include, but not be limited to:*

*(1) the quality of the service to be offered is likely to be compromised through insufficient volumes or utilization;*

*(2) the service is dependent upon the availability of scarce natural resources such as human organs;*

*(3) the operating costs associated with the service are reimbursed by major third party payors on a cost reimbursement basis; or*

*(4) the service involves the use of new technology.*

*(e) Any changes to the list required under subsection (d) and proposed by regulation shall be developed by the department after consultation with the policy board.*

*(f) A facility providing treatment solely on the basis of prayer or spiritual means in accordance with the tenets of any church or religious denomination or a facility conducted by a religious organization for the purpose of providing health care services exclusively to clergy or other persons in a religious profession who are members of the religious denomination conducting the facility shall not be considered to constitute a health service subject to review under this act.*

*(g) As used in this section, "new high-cost technology" means new technological equipment with an aggregate purchase cost of greater than \$500,000. The department shall consult with national medical and surgical speciality organizations recognized by the American Board of Medical Specialities (ABMS) and other nationally recognized scientific resources in the determination of what constitutes new technological equipment.*

Section 14. Section 702 of the act, amended July 12, 1980 (P.L.655, No.136) and repealed in part December 20, 1982 (P.L.1409, No.326), is amended to read:

Section 702. Certificates of need; notice of intent; application; issuance.

*(a) Projects [for facilities, services or equipment] requiring a certificate of need shall, at the earliest possible time in their planning, be submitted to [the health systems agency and] the department in a letter of intent in such detail advising of the scope and nature of the project as required by regulations. Within 30 days after receipt of the letter of intent, the department shall inform the applicant providing the letter of intent whether the proposed project is subject to a certificate of need review or if additional information is required to make that determination. If the department determines that the*



*project is subject to a certificate of need review, the project shall be subject to the remaining provisions of this act.*

(b) A person desiring to obtain or amend a certificate of need shall apply *in writing* to the [local health systems agency, if any, and to the department simultaneously supplying to them such information as is required by rules and regulations] *department, supplying such information as is required by the department and certifying that all data, information and statements are factual to the best of their knowledge, information and belief.* The [health systems agency and the] department shall have [20] *60* [business] days after receipt of the application within which to [determine whether] *assess* the application [is complete] and in which to request specific further information. If further information is requested, the [agency requiring the same shall determine whether] *department shall complete its preliminary assessment of* the application [is complete] within [15] *45* [business] days of receipt of the same. No information shall be required that is not specified in the rules and regulations promulgated by the department.

(c) Timely notice of the beginning of review of the application by the [health systems agency shall be sent with the notice of a completed application, upon the expiration of the time to determine that an application is complete, or 60 days or more after the filing of the application upon written demand by the applicant that review begin, whichever shall first occur, and the review shall be completed within 60 days of the "date of notification" unless the applicant agrees in writing to a specified extension of time for the review by the health systems agency. A health systems agency shall have, at least, 60 days to complete its review unless the health systems agency waives such time in writing.] *department shall be published after preliminary assessment of the application is completed by the department.* The "date of notification" of the beginning of review shall be the date such notice is sent, or the date such notice is published in *the Pennsylvania Bulletin or in a newspaper of general circulation, whichever is [later] latest.*

(d) The department shall [consider the timely filed recommendations or objections of the health systems agency in reviewing the application and shall approve or disapprove the application, unless there is an agreed extension in writing, within 30 days from receipt of the health systems agency report or report on a hearing for reconsideration before the health systems agency, whichever is later, or upon the expiration of the time for filing the same. If no action is taken within the time permitted the department to make its findings, the applicant may, following expiration of that time period, bring an action in Court to require the department to approve or disapprove the application and the court shall promptly issue such an order upon proof that the period has been exceeded. If permitted by amendment of the Federal law or regulation any application upon which action is not taken within the prescribed time shall be deemed needed and the department shall have no right of appeal with respect thereto. No new institutional health service shall be granted a certificate of need unless found or deemed to be found needed by the department or on appeal therefrom.] *approve or disapprove the application within 90 days from the date of notification of the beginning of the review unless the period for review is extended by the applicant in writing.*

(e) (1) Certificates of need shall be granted or refused. They shall not be conditioned upon the applicant changing other aspects of its facilities or services or requiring the applicant to meet other specified requirements, and no such condition shall be imposed by the department [or the health systems agency] in granting or refusing approval [or recommendation] of *certificates of need*.

(2) A certificate of need shall state the maximum amount of expenditures which may be obligated under it and applicants proceeding with an approved project may not exceed this level of expenditure except as allowed under the conditions and procedures established by the department through regulation.

(f) (1) The department shall make written findings which state the basis for any final decision made by the department. Such findings shall be [served upon the applicant, the health systems agency or agencies, and all parties to the proceedings, and shall be made available to others upon request.] *served upon the applicant and provided to all persons expressing an interest in the proceedings and shall be made available to others upon written request.*

(2) All decisions of the department shall be based solely on the record. No ex parte contact regarding the application between any employee of the department who exercises responsibilities respecting the application and the applicant, any person acting on behalf of the applicant or any person opposed to the issuance of the certificate of need shall occur after the commencement of a hearing on the application and before a decision is made by the department.

***[(g) When the department makes a decision regarding the proposed new institutional health service which is inconsistent with the recommendation made with respect thereto by a health systems agency, or with the applicable health systems plan or annual implementation plan, the department shall submit to such health systems agency and all parties to the proceeding a written, detailed statement of the reasons for the inconsistency.***

***[(h)] (g) Modification of the application at any stage of the proceeding shall not extend the time limits provided by this act unless the [health systems agency] department expressly finds that the modification represents a substantial change in the character of the application.***

***[(h) The responsibility of performing certificate of need review may not be delegated by the department. The department shall consider recommendations of one or more community-based health services planning committees whose localities are affected by specific applications.***

***[(i) (1) Before any person enters into a contractual arrangement to acquire major medical equipment which will not be owned by or located in a health care facility or before any person acquires an existing health care facility, such person shall notify the department of such person's intent to acquire such equipment or existing health care facility.***

***(2) The notice shall be in writing in a form specified by the department and shall be made at least 30 days before contractual arrangements are entered into to acquire the major medical equipment or the existing health care facility.***

(3) In the case of the intended acquisition of major medical equipment, the notice shall contain information regarding the use that will be made of the equipment. In the case of the intended acquisition of an existing health care facility, the notice shall contain information with regard to the services to be offered in the facility and its bed capacity.

(4) Within 30 days after the receipt of the notice, the department shall inform the person providing the notice whether or not the proposed acquisition is a new institutional health service. If the department determines that the acquisition will be a new institutional health service, the acquisition shall be subject to the remaining provisions of this act.

(5) A decision of the department that an acquisition requires a certificate of need may be appealed to the Health Facility Hearing Board.

(j) (1) (i) The department [shall] *may* provide [for] *that* categories of projects [which] shall receive simultaneous and comparative review. [and periods in which applications for such projects must be received (and prohibiting submission of applications outside such periods). The time between the beginning of any such period and the beginning of the next succeeding period for submission of applications for any category shall not exceed four months. No project shall be subject to such submission limitations if a notice of intent to submit an application for the project is submitted prior to the publication in the Pennsylvania Bulletin of a notice of proposed rule making by the department to establish a category subject to submission limitations.

(2) The following projects shall be exempt from any of the above batching provisions set forth in paragraph (1):

(i) Replacement of equipment not involving a substantial change in functional capacity or capability.

(ii) Renovations necessary to meet code requirements which do not expand the capacity of the facility or involve the addition of new services.

(iii) Repairs or reconstruction in the cases of emergency.

(iv) Installation of equipment or renovations which will save energy but which do not expand the capacity of the facility or involve the addition of a new service.]

Section 15. Section 704 of the act, amended July 12, 1980 (P.L.655, No.136), is amended to read:

Section 704. [Hearings before the department] *Notice of public meetings.*

(a) The function of holding a public hearing is hereby delegated to the appropriate HSA unless the department and the HSA agree otherwise in writing in a particular case. If a public hearing has been held by the health systems agency, no hearing shall be held by the department in reaching its final decision. If there has been no provision for such hearings before the health systems agency, the department shall provide notice of a public hearing and conduct that hearing in accordance with the provisions of section 703(b).

(b) Any person may, for good cause shown, request, in writing, a public hearing for the purpose of reconsideration of a decision of the department within ten days of service of the decision of the department. The department

shall set forth the cause for the hearing and the issues to be considered at such hearing. If such hearing is granted, it shall be held no sooner than six days and no later than 14 days after such request is made, and may be limited to the issues submitted for reconsideration. A summary of the oral testimony shall be made of the hearing, and copies thereof supplied at cost to the parties. The department shall affirm or reverse its decision and submit the same to the parties, the persons requesting the hearing, and the health systems agency within 14 days of the conclusion of such hearing. Any change in the decision shall be supported by the reasons therefor.

(c) Where hearings are held on more than two days, consecutive days of hearings and intervening weekends and holidays shall be excluded in calculating the time permitted for the department to conduct its review, and if briefs are to be filed, ten days subsequent to the adjournment of the hearing shall also be excluded.]

*(a) Notification of the beginning of review of a certificate of need application shall be published by the department in the appropriate news media and in the Pennsylvania Bulletin in accordance with 45 Pa. C.S. Ch. 7 Subch. B (relating to publication of documents). The notice shall identify the schedule for review, the date by which a public meeting must be requested and the manner in which notice will be given of a meeting, if one is held.*

*(b) Interested persons may request a public meeting within 15 days of publication, and the department shall hold such a meeting or the department may require a public meeting during the course of such review. The department shall publish written notice of the meeting in the appropriate news media and the Pennsylvania Bulletin at least 14 days prior to the public meeting date. In the meeting, the applicant and any interested person providing prior notice to the department shall have the right to present oral or written comments and relevant evidence on the application in the manner prescribed by the department. The department shall prepare a transcript of the oral testimony presented at the meeting. Meetings shall be held in accordance with the guidelines and procedures established by the department and published in the Pennsylvania Code as a statement of policy. The department may require the applicant to provide copies of the application to any interested person making a request for such application, at the expense of the interested person.*

*(c) The applicant may, for good cause shown, request in writing a public hearing for the purpose of reconsideration of a decision of the department within ten days of service of the decision of the department. The department shall treat the request in accordance with the provisions of 1 Pa. Code § 35.241 (relating to application for rehearing or reconsideration). The department shall set forth the cause for the hearing and the issues to be considered at such hearing. If such hearing is granted, it shall be held no sooner than six days and no later than 30 days after the notice to grant such a hearing and shall be limited to the issues submitted for reconsideration. A transcript shall be made of the hearing and a copy of the transcript shall be provided at cost to the applicant. The department shall affirm or reverse its decision and submit the same to the person requesting the hearing within 30*

*days of the conclusion of such hearing. Any change in the decision shall be supported by the reasons for the change.*

*(d) Where hearings under subsection (b) are held on more than two days, consecutive days of hearings and intervening weekends and holidays shall be excluded in calculating the time permitted for the department to conduct its review, and, if briefs are to be filed, ten days subsequent to the adjournment of the hearing shall also be excluded.*

Section 16. Sections 705 and 706 of the act are amended to read:

Section 705. Good cause.

Good cause shall be deemed to have been shown if:

- (1) there is significant, relevant information not previously considered;
- (2) there is significant change in factors or circumstances relied on in making the decision;
- (3) there has been material failure to comply with the procedural requirements of this act; or
- [(4) the department determines that there is good cause shown for some other reason.]

If good cause as to items (1) and (2) above is found by the department, the application shall be remanded for consideration with respect to such factors to the health systems agency for consideration of the same. The time, not to exceed 45 days, that the application is before the health systems agency for such consideration shall not be counted in determining the time within which the department shall take action on the application.]

*(4) good cause is otherwise found to exist.*

Section 706. Information during review.

During the course of review [the health systems agency and] the department shall upon request of any person[,] set forth the status, any findings [then] made in the proceeding and other appropriate information requested. *The department may require such requests to be in writing.*

Section 17. Section 707 of the act, amended July 12, 1980 (P.L.655, No.136), is amended to read:

Section 707. Criteria for review of applications for certificates of need or amendments.

**[(a) An application for a certificate of need shall be recommended, approved, and issued when the application substantially meets the requirements listed below; provided that each decision, except in circumstances which pose a threat to public health, shall be consistent with the State health plan:**

- (1) The relationship of the application with the applicable health systems plan and annual implementation plan has been considered.**
- (2) The services are compatible to the long-range development plan (if any) of the applicant.**
- (3) There is a need by the population served or to be served by the services.**
- (4) There is no appropriate, less costly, or more effective alternative methods of providing the services available.**

(5) The service or facility is economically feasible, considering anticipated volume of care, the capability of the service area to meet reasonable charges for the service or facility and the availability of financing.

(6) The proposed service or facility is financially feasible both on an intermediate and long-term basis and the impact on cost of and charges for providing services by the applicant is appropriate.

(7) The proposed service or facility is compatible with the existing health care system in the area.

(8) The service or facility is justified by community need and within the financial capabilities of the institution both on an intermediate and long-term basis and will not have an inappropriate, adverse impact on the overall cost of providing health services in the area.

(9) There are available resources (including health manpower, management personnel, and funds for capital and operating needs) to the applicant for the provision of the services proposed to be provided, and there is no greater need for alternative uses for such resources for the provision of other health services. The effect on the clinical needs of health professional training programs in the medical service area, the extent to which health professional schools in the medical service area will have access to the services for training purposes and the extent to which the proposed service will be accessible to all residents of the area to be served by such services have been considered.

(10) The proposed service or facility will have available to it appropriate ancillary and support services and an appropriate organizational relationship to such services.

(11) The proposed services are consistent with the special needs and circumstances of those entities which provide services or resources both within and without the health service area in which the proposed services are to be located, including medical and other health professional schools, multidisciplinary clinics, and specialty centers.

(12) The special needs and circumstances of health maintenance organizations shall be considered to the extent required by Federal law and regulation now or hereafter enacted or adopted.

(13) The proposed services are not incompatible with any biomedical or behavioral research projects designed for national need for which local conditions offer special advantages.

(14) Consideration of the need and availability in the community for services and facilities for allopathic and osteopathic physicians and their patients; and the religious orientation of the facility and the religious needs of the community to be served. This provision is not intended to create duplicative systems of care.

(15) The factors which affect the effect of competition on the supply of health services being reviewed with particular reference to the existence and the capacity of market conditions in advancing the purposes of quality assurance, cost containment and responsiveness to consumer preferences and the existence and capacity of utilization review programs and other public and private cost control measures to give effect to consumer prefer-

ences and to establish appropriate incentives for capital allocations have been considered.

(16) Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance, cost effectiveness and responsiveness to consumer preferences have been given preference.

(17) The efficiency and appropriateness of the use of existing services and facilities similar to those proposed has been considered.

(18) In the case of existing services for facilities, the quality of care provided by services or facilities in the past has been considered.

(19) The contribution of the proposed new institutional health service in meeting the health related needs of members of medically underserved groups has been considered in written findings.

(20) The special circumstances of applications with respect to the need for conserving energy have been considered.

(b) If the application is for a proposed service or facility which includes a construction project, a certificate of need shall be recommended, approved and issued when the provisions of subsection (a) are satisfied, and:

(1) the costs and methods of proposed construction including the costs and methods of energy provision are appropriate; and

(2) the impact on the costs of providing health services by the applicant resulting from the construction is found to be appropriate and the impact on the costs and charges to the public of providing health services by other persons is found to be not inappropriate.

(c) Whenever new institutional health services for inpatients are proposed, a finding shall be made in writing by the reviewing authority:

(1) as to the efficiency and appropriateness of the existing use of the inpatient facilities similar to those proposed;

(2) as to the capital and operating costs, efficiency and appropriateness of the proposed new service and its potential impact on patient charges;

(3) that less costly alternatives which are more efficient and more appropriate to such inpatient service are not available and the development of such alternatives has been studied and found not practicable;

(4) that existing inpatient facilities providing inpatient services similar to those proposed are being used in an appropriate and efficient manner;

(5) that in the case of new construction, alternatives to new construction such as modernization or sharing arrangements have been considered and have been implemented to the maximum extent practicable;

(6) that patients will experience serious problems in terms of cost, availability, accessibility or such other problems as are identified by the reviewing agency in obtaining inpatient care of the type proposed in the absence of the proposed new service; and

(7) that in the case of a proposal for the addition of beds for the provision of skilled nursing or intermediate care services, the addition will be consistent with the plans of the agency, if any, that is responsible for the provision and financing of long-term care services.

A certificate of need shall be issued for inpatient services when the provisions of subsections (a) and (b) are satisfied and the findings of this subsection can be made.]

*(a) An application for certificate of need shall be considered for approval when the department determines that the application substantially meets the requirements listed below:*

*(1) There is need by the population served or to be served by the proposed service or facility.*

*(2) The proposed service or facility will provide care consistent with quality standards established by the State health services plan.*

*(3) The proposed service or facility will meet the standards identified in the State health services plan for access to care by medically underserved groups, including individuals eligible for medical assistance and persons without health insurance.*

*(b) The department shall issue a certificate of need if the project substantially meets the criteria of subsection (a)(1), (2) and (3) and the project is consistent with the State health services plan unless the department can demonstrate:*

*(1) There is a more appropriate, less costly or more effective alternative method of providing the proposed services.*

*(2) The service or facility is not financially and economically feasible, considering anticipated volume of care and the availability of reasonable financing based on information received from the applicant and other sources during the review process.*

*(3) The proposed service or facility will have an inappropriate, adverse impact on the overall level of health care expenditures in the area.*

*(4) The proposed service or facility adversely impacts the maintenance and development of rural and inner-city health services generally and, in particular, those services provided by health care providers which are based in rural and inner-city locations and which have an established history of providing services to medically underserved populations.*

*[(d)] (c) Notwithstanding the provisions of subsections (a)[, (b) and (c)] and (b), applications for projects described in subsection [(e)] (d) shall be approved unless the department finds that the facility or service with respect to such expenditure as proposed is not needed or that the project is not consistent with the State health services plan. An application made under this subsection shall be approved only to the extent that the department determines it is required to overcome the conditions described in subsection [(e)] (d).*

*[(e)] (d) Subject to the provisions of subsection [(d)] (c), subsections (a)[, (b) and (c)] and (b) shall not apply to capital expenditures required to:*

*(1) [Eliminate] eliminate or prevent imminent safety hazards as a result of violations of safety codes or regulations[.];*

*(2) [Comply] comply with State licensure standards[.]; or*

*(3) [Comply] comply with accreditation standards, compliance with which is required to receive reimbursement or payments under Title XVIII or XIX of the Federal Social Security Act.*



Section 18. Section 708 of the act is repealed.

Section 19. The act is amended by adding a section to read:

**Section 708.1. Monitoring certificate of need; expiration of a certificate of need.**

*A certificate of need or an amendment to it shall expire two years from the date issued unless substantially implemented, as defined by regulation. The department may grant extensions for a specified time upon request of the applicant and upon a showing that the applicant has or is making a good faith effort to substantially implement the project. An expired certificate of need shall be invalid, and no person may proceed to undertake any activity pursuant to it for which a certificate of need or amendment is required. The applicant shall report to the department, on forms prescribed by the department, the status of the project until such time as the project is licensed or operational, if no license is required.*

Section 20. Section 709 of the act is amended to read:

**Section 709. Emergencies.**

Notwithstanding any other provision of this act, [and pursuant to an agreement with the United States Department of Health, Education and Welfare,] in the event of an emergency the department may suspend the foregoing application process and permit such steps to be taken as may be required to meet the emergency including the replacement of equipment or facilities.

Section 21. Sections 711, 802.1, 804, 806, 807, 808, 809, 810, 811 and 812 of the act, amended or added July 12, 1980 (P.L.655, No.136), are amended to read:

**Section 711. Review of activities.**

(a) The department [and each health systems agency] shall prepare and publish not less frequently than annually reports of reviews conducted under this act, including a statement on the status of each such review and of reviews completed by [them, including statements of the finding and] *it and statements of the* decisions made in the course of such reviews since the last report. The department [and each health systems agency] shall also make available to the general public for examination at reasonable times of the business day all applications reviewed by [them and all written materials on file at the agency pertinent to such review.] *it. Such reports and applications shall be considered public records.*

(b) The [department in its] *department's* report which shall be submitted to the members of the Health and Welfare Committees of the Senate and House of Representatives shall contain the following information [classified by health system areas]:

(1) The volume of applications submitted, by project type, their dollar value, and the numbers and costs associated with those approved and those not approved.

[(2) An estimate of the operating cost impact of the approved projects.

(3) The average time for review, by project type.

(4)] (2) The assessment of the extent of competition in specific service sectors that guided decisions.

[(5)] (3) A detailed description of projects involving nontraditional or innovative service delivery methods or organizational arrangements and the decisions made on each of these projects.

(4) *The average time for review, by level of review.*

(5) *The fees collected for reviews and the cost of the program.*

#### Section 802.1. Definitions.

The following words and phrases when used in this chapter shall have, unless the context clearly indicates otherwise, the meanings given them in this section:

“Ambulatory surgical facility.” A facility or portion thereof not located upon the premises of a hospital which provides *specialty or multispecialty* outpatient surgical treatment. Ambulatory surgical facility does not include individual or group practice offices of private physicians or dentists, unless such offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis. For the purposes of this provision, outpatient surgical treatment means surgical treatment to patients who do not require hospitalization, but who require constant medical supervision following the surgical procedure performed.

“Birth center.” A facility not part of a hospital which provides maternity care to childbearing families not requiring hospitalization. A birth center provides a home-like atmosphere for maternity care, including prenatal labor delivery and postpartum care related to medically uncomplicated pregnancies.

“Health care facility.” [A general, tuberculosis,] *For purposes of Chapter 8, a health care facility includes, but is not limited to, a general, chronic disease or other type of hospital, [a skilled nursing facility,] a home health care agency, [an intermediate care] a long-term care nursing facility, cancer treatment centers using radiation therapy on an ambulatory basis, an ambulatory surgical facility, a birth center* regardless of whether such health care facility is operated for profit, nonprofit or by an agency of the Commonwealth or local government. *The department shall have the authority to license other health care facilities as may be necessary due to emergence of new modes of health care. When the department so finds, it shall publish its intention to license a particular type of health care facility in the Pennsylvania Bulletin in accordance with the act of June 25, 1982 (P.L.633, No.181), known as the “Regulatory Review Act.”* The term health care facility shall not include an office used primarily for the private practice of [medicine, osteopathy, optometry, chiropractic, podiatry or dentistry,] *a health care practitioner*, nor a program which renders treatment or care for drug or alcohol abuse or dependence unless located within a health facility, nor a facility providing treatment solely on the basis of prayer or spiritual means. [A mental retardation facility is not a health care facility except to the extent that it provides skilled nursing care.] The term health care facility shall not apply to a facility which is conducted by a religious organization for the purpose of providing health care services exclusively to clergymen or other

persons in a religious profession who are members of a religious denomination.

**["Health care provider" or "provider." An individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), the Commonwealth, or a political subdivision or instrumentality (including a municipal corporation or authority) thereof, that operates a health care facility.]**

**"Home health care agency." An organization or part thereof staffed and equipped to provide nursing and at least one therapeutic service to *persons who are* disabled, aged, injured or sick [persons] in their place of residence. The agency may also provide other health-related services to protect and maintain persons in their own home.**

**"Hospital." An institution having an organized medical staff [which is primarily engaged in] *established for the purpose of* providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of *persons who are* injured, disabled, pregnant, diseased [or], sick or mentally ill [persons,] or rehabilitation services for the rehabilitation of *persons who are* injured, disabled, pregnant, diseased [or], sick or mentally ill [persons]. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for the mentally ill.**

**["Intermediate care facility." An institution which provides on a regular basis health-related care and services to resident individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require health-related care and services above the level of room and board. Intermediate care facilities exclusively for the mentally retarded commonly called ICF/MR shall not be considered intermediate care facilities for the purpose of this act and shall be licensed by the Department of Public Welfare.**

**"Skilled nursing facility." Any facility or part of a facility in which professionally supervised nursing care and related medical and other health services are provided for a period exceeding 24 hours for two or more individuals who are not in need of hospitalization and are not relatives of the nursing home administrator, but who because of age, illness, disease, injury convalescence or physical or mental infirmity need such care.]**

**"Long-term care nursing facility." A facility that provides either skilled or intermediate nursing care or both levels of care to two or more patients, who are unrelated to the licensee, for a period exceeding 24 hours. Intermediate care facilities exclusively for the mentally retarded, commonly called ICF/MR, shall not be considered long-term care nursing facilities for the purpose of this act and shall be licensed by the Department of Public Welfare.**

Section 804. Administration.

(a) Discrimination prohibited.—Except as otherwise provided by law, no provider shall discriminate in the operation of a health care facility on the basis of race, creed, sex or national origin.

(b) **Prevention of duplication.**—In carrying out the provisions of this chapter and other statutes of this Commonwealth relating to health care facilities, the department and other departments and agencies of the State and local governments shall make every reasonable effort to prevent duplication of inspections and examinations. **[Within 12 months of the enactment date of this chapter, the department shall establish subject to the approval of the Governor a method of scheduling inspections whereby inspections of health care facilities by all departments and agencies of the Commonwealth shall be coordinated insofar as reasonably possible. Within 24 months of the enactment date of this chapter, the department shall make the dates of expiration of Medicaid and Medicare certification coincide with licensure and shall subsequently] *The department may make the dates of licensure expiration coincide with medical assistance and Medicare certification or applicable nationally recognized accrediting agencies accreditation and shall combine these surveys and inspections where practical.***

(c) **Health care innovation.**—The department shall administer this chapter so as to encourage innovation and experimentation in health care and health care facilities *consistent with the provisions of this chapter* and shall encourage contributions of private funds and services to health care facilities.

(d) **Reports.**—The department shall report annually to the General Assembly on the effectiveness of the licensing and enforcement of this chapter. Such report shall include appropriate data according to nature of facility relating to provisional licenses issued, nature of violations of regulations[,] *and number of facilities against which sanctions had to be taken. [and the number of facilities with pending serious violations. The report shall also include recommendations for statutory and administrative changes which the department deems desirable to enhance the quality of care provided by health care facilities.]*

Section 806. Licensure.

(a) **License required.**—No person shall maintain or operate a health care facility without first having obtained a license therefor issued by the department. No health care facility can be a provider of medical assistance services unless it is licensed by the department and certified as a medical assistance provider.

(b) **Development of regulations.**—In developing rules and regulations for licensure the department shall take into consideration **[conditions for participation in government and] *Federal certification standards and the standards of other third party [payments] payors for health care services and [the standards of the Joint Commission on Accreditation of Hospitals, the Committee on Hospital Accreditation of the American Osteopathic Association and such other accrediting bodies] such nationally recognized accrediting agencies*** as the department may find appropriate.

(c) **Fire and emergency standards.**—Notwithstanding any other provision of law other than standards required **[by the Federal Government as a condition of participation] for *Federal certification*** by that type of health care facility in the Medicare or Medicaid program, no health care facility

shall be required to satisfy any regulation relating to fire or similar emergency circumstance more stringent than those required of hospitals by the Joint Commission on Accreditation of **[Hospitals] Health Organizations or such nationally recognized accrediting agencies as the department may find appropriate**, and the department shall adopt and enforce the appropriate standards.

(d) Home health care agency regulations.—In developing rules and regulations for licensure of home health care agencies the department shall take into consideration the standards of **[the National Association of Home Health Agencies, National League of Nursing, Joint Commission on the Accreditation of Hospitals and National Council for Homemakers, Home Health Aides and other accrediting bodies] nationally recognized accrediting agencies** as the department may find appropriate. Home health care agencies certified as providers by the department to the Federal Government for purposes of the Medicare program shall be deemed to comply with and satisfy the department's regulations governing home health care agencies.

(e) Public disclosure.—**[Rules and regulations of the department shall require:**

(1) The licensee to provide to the appropriate health systems agency information that the health systems agency is required to collect pursuant to section 1513(b) of the Federal National Health Planning and Resources Development Act.

(2) The licensee to make available to the public upon request the licensee's current daily cost reimbursement under Blue Cross, medical assistance and Medicare as well as the average daily charge to other insured and noninsured private pay patients.

(3) Disclosure of the persons owning 5% or more of the licensee as well as the licensee's officers and members of the board of directors.] *The department shall require disclosure of the persons owning 5% or more of the health care facility as well as the health care facility's officers and members of the board of directors.*

(f) *Ambulatory surgical facilities standards.—Within one year of the effective date of this act, to the extent possible, the department shall publish in the Pennsylvania Bulletin proposed regulations establishing revised standards for licensure of ambulatory surgical facilities. Such standards shall provide for separate licensure criteria for office-based surgical facilities and for comprehensive freestanding ambulatory surgical facilities, including, but not limited to:*

(1) *fire and safety standards;*

(2) *personnel and equipment requirements; and*

(3) *quality assurance procedures.*

*The purpose of such criteria shall be to assure quality care delivery in said facilities. Until such time the revised regulations are adopted, the existing rules and regulations governing the licensure of ambulatory surgical facilities shall apply.*

## Section 807. Application for license.

(a) Submission to department.—Any person desiring to secure a license to maintain and operate a health care facility shall submit an application therefor to the department upon forms prepared and furnished by it, containing such information as the department considers necessary to determine that the health care provider and the health care facility meet the requirements of licensure under the provisions of this act and the rules and regulations relating to licensure. Application for renewal of a license shall be made upon forms prepared and furnished by the department in accordance with the rules and regulations of the department.

(b) Fees.—Application for a license or for renewal of a license shall be accompanied by [a fee of \$50 plus \$2 for each inpatient bed in excess of 75 beds.] the following fees:

<i>(1) Regular or special license:</i>	
<i>Home health agency</i>	<i>\$250.00</i>
<i>Ambulatory surgical facility</i>	<i>250.00</i>
<i>Birth center</i>	<i>70.00</i>
<i>Long-term care nursing facility</i>	<i>250.00</i>
<i>Plus per each long-term care bed in excess of</i>	
<i>75 beds</i>	<i>2.00</i>
<i>Hospital</i>	
<i>Every two years</i>	<i>500.00</i>
<i>Plus per each inpatient bed</i>	
<i>every two years</i>	<i>4.00</i>
<i>Other health care facility</i>	<i>100.00</i>
<i>(2) Provisional license all facilities:</i>	
<i>Provisional I</i>	<i>\$400.00</i>
<i>Plus per each inpatient bed</i>	<i>4.00</i>
<i>Provisional II</i>	<i>600.00</i>
<i>Plus per each inpatient bed</i>	<i>6.00</i>
<i>Provisional III</i>	<i>800.00</i>
<i>Plus per each inpatient bed</i>	<i>8.00</i>
<i>Provisional IV</i>	<i>1,000.00</i>
<i>Plus per each inpatient bed</i>	<i>10.00</i>

(c) Bond.—The department by regulations may require new applicants for a license to post a bond.

## Section 808. Issuance of license.

(a) Standards.—The department shall issue a license to a health care provider when it is satisfied that the following standards have been met:

- (1) that the health care provider is a responsible person;
- (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered;
- (3) that the health care facility provides safe and efficient services which are adequate for the care, treatment and comfort of the patients or residents of such facility;

(4) that there is substantial compliance with the rules and regulations adopted by the department pursuant to this act; and

(5) that a certificate of need has been issued if one is necessary.

(b) **Separate and limited licenses.**—Separate licenses shall not be required for different services within a single health care facility except that home health care or [skilled or intermediate] *long-term* nursing care will require separate licenses. [A single facility providing both skilled and intermediate care shall need only one separate license to cover those services.] A limited license, excluding from its terms a particular service or portion of a health care facility, may be issued under the provisions of this act.

(c) **[Modification of license] Addition of services.**—When the certificate of need for a facility is amended as to services which can be offered, the department shall issue [a modified] *an appropriate* license for those services upon demonstration of compliance with licensure requirements.

Section 809. Term and content of license.

(a) **Contents.**—All licenses issued by the department under this chapter shall:

(1) **[with the exception of provisional licenses for health care facilities other than hospitals expire one year from the date on which issued and for hospitals expire two years from the date on which issued unless renewed;] be issued for a specified length of time as follows, including the provision of section 804(b):**

(i) *all health care facilities other than hospitals for a period of one year, and for hospitals for a period of two years with the expiration date to be the last day of the month in which license is issued;*

(ii) *provisional licenses for the length of time to be determined by the department upon issuance of the provisional license;*

(2) be on a form prescribed by the department;

(3) not be transferable except upon prior written approval of the department;

(4) be issued only to the health care provider and for the health care facility or facilities named in the application;

(5) specify the maximum number of beds, if any, to be used for the care of patients in the facility at any one time; and

(6) specify [whether the license has been granted to the health care facility as a whole or, if not, shall specify those portions of or services offered by the facility which have been excluded from the terms of the license] *limitations which have been placed on the facility.*

(b) **Posting.**—The license shall at all times be posted in a conspicuous place on the provider's premises.

(c) **Visitation.**—Whenever practicable, the department shall make its visitations and other reviews necessary for licensure contemporaneously with similar visitations and other reviews necessary for provider certification in the Medicare and medical assistance programs and the department shall endeavor to avoid duplication of effort by the department and providers in the certificate of need, medical assistance and Medicare provider certification and licensure procedures. This shall not preclude the department from unannounced visits.

(d) Use of beds in excess of maximum.—Except in case of extreme emergency, no license shall permit the use of beds for inpatient use in the licensed facility in excess of the maximum number set forth in the license without first obtaining written permission from the department: Provided, That during the period of a license, a health care facility may without the prior approval of the department increase the total number of beds by not more than ten beds or 10% of the total bed capacity, whichever is less.

Section 810. Reliance on accrediting agencies and Federal Government.

(a) Reports of other agencies.—After a provider has been licensed or approved to operate a health care facility for at least **[three] two** years under this or prior acts, none of which has been pursuant to a provisional license, the department may rely on the reports of the Federal Government or nationally recognized accrediting agencies **[if the government or agency standards are substantially]** *to the extent those standards are determined by the department to be* similar to regulations of the department and if the provider agrees to:

(1) direct the agency or government to provide a copy of its findings to the department; and

(2) permit the department to inspect those areas or programs of the health care facility not covered by the agency or government inspection or where the agency or government report discloses more than a minimal violation of department regulations.

(b) Coordination of inspections.—**[All State agencies and all divisions or units of such agencies which conduct regular on-site inspections of health care facilities shall, within 120 days of the enactment of this amendatory act, advise the department of the type of inspections they conduct, the time required to inspect and the frequency of such inspections. In accordance with the plan approved by the Governor, the]** *The* department shall coordinate, to the extent possible, inspections by State agencies other than the department **[and shall advise other agencies which inspections shall be made only after written notice to the department and may require other State agencies to make their inspections simultaneously with the inspection by the department]**. Nothing herein shall be interpreted to preclude the department from any follow-up inspection of a health care facility in which deficiencies were found in the original inspections or more frequent inspections of health care facilities that received provisional licenses.

(c) Right of inspection preserved.—This section shall not be construed to be a limitation on the department's right of inspection otherwise permitted by section 813.

Section 811. Reasons for revocation or nonrenewal of license.

The department may refuse to renew a license or may suspend or revoke or limit a license for all or any portion of a health care facility, or for any particular service offered by a facility, or may suspend admissions for any of the following reasons:

(1) A serious violation of provisions of this act or of the regulations for licensure issued pursuant to this act or of Federal laws and regulations. For the purpose of this paragraph, a serious violation is one which poses a



significant threat to the health [of patients] or safety of patients or residents.

(2) Failure of a licensee to submit a plan with a reasonable timetable to correct deficiencies.

(3) The existence of a cyclical pattern of deficiencies over a period of two or more years.

(4) Failure, by the holder of a provisional license, to correct deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the department.

(5) Fraud or deceit in obtaining or attempting to obtain a license.

(6) Lending, borrowing or using the license of another, or in any way knowingly aiding or abetting the improper granting of a license.

(7) Incompetence, negligence or misconduct in operating the health care facility or in providing services to patients.

(8) Mistreating or abusing individuals cared for by the health care facility.

(9) Serious violation of the laws relating to medical assistance or Medicare reimbursement.

(10) *Serious violation of other applicable Federal or State laws.*

Section 812. Provisional license.

**[When there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations, and when the department finds:**

(1) the applicant is taking appropriate steps to correct the deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the department; and

(2) there is no cyclical pattern of deficiencies over a period of two or more years, then the department may issue a provisional license for a specified period of not more than six months which may be renewed three times at the discretion of the department.

**Upon overall compliance, a regular license shall be issued.]**

*When there are numerous deficiencies or a serious specific deficiency in compliance with applicable statutes, ordinances or regulations and when the department finds the applicant is taking appropriate steps to correct the deficiencies in accordance with a timetable submitted by the applicant and agreed upon by the department and there is no cyclical pattern of deficiencies over a period of two or more years, then the department may issue a provisional license for a specified period of not more than six months which may be renewed three times at the discretion of the department. Upon substantial compliance, including payment of any fines levied pursuant to section 817(d), a regular license shall be issued.*

Section 22. Section 814 of the act, added July 12, 1980 (P.L.655, No.136) and repealed in part December 20, 1982 (P.L.1409, No.326), is amended to read:

Section 814. Provider violations.

(a) Notice of violations.—Whenever the department shall upon inspection, investigation or complaint find a violation of this chapter or regulations

adopted by the department pursuant to this chapter or pursuant to Federal law, it shall give written notice thereof specifying the violation or violations found to the health care provider. Such notice shall require the health care provider to take action or to submit a plan of correction which shall bring the health care facility into compliance with applicable law or regulation within a specified time. The plan of correction must be submitted within 30 days of receipt of the written notice *or sooner if directed to do so by the department. The department may ban admissions or revoke a license before a plan of correction is submitted whenever deficiencies pose a significant threat to the health or safety of patients or residents.*

(b) **Appointment of [master] temporary management.**—When the health care provider has failed to bring the facility into compliance within the time [so] specified *by the department*, or when the facility has demonstrated [a pattern of episodes of noncompliance alternating with compliance over a period of at least two years] *that it is unwilling or unable to achieve compliance*, such as would convince a reasonable person that any correction of violations would be unlikely to be maintained, the department may petition the *Commonwealth Court or the Court of Common Pleas of the county in which the facility is located* to appoint [a master] *temporary management* designated as qualified by the department to assume operation of the facility at the facility's expense [for a specified period of time or until all violations are corrected and all applicable laws and regulations are complied with, or] *to assure the health and safety of the facility's patients or residents until improvements are made to bring the facility into compliance with the laws and regulations for licensure or until there is an orderly closure of the facility. In the alternative*, the department in its discretion may proceed in accordance with this chapter.

Section 23. Sections 817 and 820 of the act, added July 12, 1980 (P.L.655, No.136), are amended to read:

Section 817. Actions against violations of law, rules and regulations.

(a) **Actions brought by department.**—Whenever any person, regardless of whether such person is a licensee, has violated any of the provisions of this chapter or the regulations issued pursuant thereto, the department may maintain an action in the name of the Commonwealth for an injunction or other process restraining or prohibiting such person from engaging in such activity.

(b) **Civil penalty.**—Any person, regardless of whether such person is a licensee, who has committed a violation of any of the provisions of this chapter or of any rule or regulation issued pursuant thereto, including failure to correct a serious licensure violation (as defined by regulation) within the time specified in a deficiency citation, may be assessed a civil penalty by an order of the department of up to **[\$100 for each day that such violation continues.] \$500 for each deficiency for each day that each deficiency continues.** *Civil penalties shall be collected from the date the facility receives notice of the violation until the department confirms correction of such violation.*

(c) **Funds collected as a result of the assessment of a civil penalty.**—*When all other sources of funding have been exhausted, the department shall*

*apply funds collected as a result of the assessment of a civil penalty to the protection of the health or property of patients or residents of the health care facility. Funds may be utilized to:*

- (1) Provide payment to temporary management.*
- (2) Maintain the operation of the health care facility pending correction of deficiencies or closure.*
- (3) In the case of a long-term care nursing facility, relocate residents to other licensed health care facilities.*
- (4) In the case of a long-term care nursing facility, reimburse residents for misappropriated personal needs allowance.*

*(d) Facility closure for threat to health or safety.—Whenever the department determines that deficiencies pose an immediate and serious threat to the health or safety of the patients or residents of the health care facility, the department may direct the closure of the facility and the transfer of patients or residents to other licensed health care facilities.*

Section 820. Existing rules and regulations.

*(a) Continuation of rules and regulations.—Existing rules and regulations applicable to health care facilities not clearly inconsistent with the provisions of this chapter, shall remain in effect until replaced, revised or amended. [In developing regulations, the department shall give priority to developing minimum standards for home health agencies and other health care facilities not previously subject to regulation.] Sections 103.2 and 103.6 of Title 28 of the Pennsylvania Code are repealed.*

*(b) Expiration of licenses.—All health care providers licensed[, approved or certified] on the effective date of this chapter to establish, maintain or operate a health care facility shall be licensed for the period remaining on the license[, certification or approval. If a health care facility has a license, approval or equivalent certification without an expiration date, it shall be deemed for the purposes of this section to expire one year after its date of issuance]. At the expiration of the existing license [certification or approval], the health care facility shall be subject to licensure pursuant to this chapter.*

Section 24. The act is amended by adding sections to read:

*Section 902.1. Fees for review of certificate of need applications.*

*(a) The department shall charge a fee of \$150 for each letter of intent filed. The letter of intent fee shall be deducted from the total application fee required under subsection (b) if an application is submitted on the project proposed in the letter of intent.*

*(b) For each application the department shall charge a fee, payable on submission of an application. The fee shall not be less than \$500 plus up to \$3 per \$1,000 of proposed capital expenditure and shall not be more than \$20,000.*

*(c) The department shall publish a fee schedule in the Pennsylvania Bulletin which shall explain the procedure for filing fees.*

*(d) All fees payable under this section are due upon the date of filing a letter of intent or application. If a person fails to file the appropriate fee, all time frames required of the department under this act, with respect to review of a letter of intent or application, are suspended until the applicable fee is paid in full.*

**Section 904.1. Sunset.**

*The authority, obligations and duties arising under Chapter 7 and all other provisions of this act pertaining to certificates of need shall terminate four years after the effective date of this section. Twelve months prior to this expiration, the Legislative Budget and Finance Committee shall commence a review of the impact of the certificate of need program on quality, access and cost of health care services, including the costs of appeals, reviewable under this act.*

**Section 904.2. Severability.**

*The provisions of this act are severable. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of this act which can be given effect without the invalid provision or application.*

Section 25. Any cancer treatment center required to be licensed pursuant to the provisions of this act shall obtain the required license within two years of the effective date of this act.

Section 26. (a) Articles IX and X of the act of June 13, 1967 (P.L.31, No.21), known as the Public Welfare Code, are repealed insofar as they relate to health care facilities as defined in Chapter 8 of the act.

(b) All other acts and parts of acts are repealed insofar as they are inconsistent with this act.

Section 27. This act shall take effect immediately.

APPROVED—The 18th day of December, A. D. 1992.

ROBERT P. CASEY