REPORT OF THE

JOINT SUBCOMMITTEE TO STUDY HOSPICE

OF THE

HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS

AND THE

HOUSE COMMITTEE ON CORPORATIONS, INSURANCE AND BANKING

TO

THE GOVERNOR

AND

THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 36

COMMONWEALTH OF VIRGINIA
DIVISION OF PURCHASES AND SUPPLY
RICHMOND
1979

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Report of the
Joint Subcommittee to Study Hospice
of the
House Committee on Health, Welfare and Institutions
and the

House Committee on Corporations, Insurance and Banking

To

The Governor and the General Assembly of Virginia

Richmond, Virginia

December, 1978

To: Honorable John N. Dalton, Governor of Virginia

and

The General Assembly of Virginia

The Joint Subcommittee to Study Hospice conducted its study pursuant to House Resolution Number 84 of the 1978 Session of the General Assembly. The Resolution follows:

HOUSE RESOLUTION NO. 84

Requesting a joint subcommittee of the Committee on Health, Welfare and Institutions and the Committee on Corporations, Insurance and Banking of the House of Delegates to study the necessary changes in State laws and regulations to establish hospices in Virginia.

WHEREAS, terminally ill patients and their families require palliative and supportive care which is frequently unavailable in either the hospital or in the patient's home; and

WHEREAS, it is vitally important that the terminally ill patient enjoys a comfortable atmosphere, proper medical attention and the assurance that his loved ones are suffering no undue discomfort or disturbance because of his condition; and

WHEREAS, the "hospice" is a program which provides relief from the symptoms of a terminal illness as well as providing emotional support for the patient and his family; and

WHEREAS, a study is needed to determine the changes required in State laws and regulations in order to establish hospices in the Commonwealth; now, therefore, be it

RESOLVED by the House of Delegates, That the Committee on Health, Welfare and Institutions and the Committee on Corporations, Insurance and Banking are requested to appoint a joint subcommitee to study the changes needed in State laws and regulations to establish hospices in Virginia.

The joint subcommitee shall examine all statutes and regulations pertinent to the establishment of hospices in the Commonwealth, including those statutes and regulations regarding licensure of health care programs, certificate-of-need and insurance.

In its deliberations, the joint subcommitee shall consider the research and recommendations of

the hospice study at Saint Mary's Hospital in Richmond, Virginia and the study by Hospice of Northern Virginia, Incorporated.

The joint subcommittee shall report its findings and recommendations to the nineteen hundred seventy-nine Session of the General Assembly.

In accordance with House Resolution Number 84, members of the Commitee on Health, Welfare and Institutions and of the Committee on Corporations, Insurance and Banking of the House of Delegates were chosen to serve on the Joint Subcommittee to Study Hospice. Delegate Mary A. Marshall of Arlington was elected chairman of the Joint Subcommittee. Serving with Delegate Marshall were Delegates Gerald L. Baliles of Richmond; David G. Brickley of Woodbridge; Vincent F. Callahan, Jr. of McLean; Walter H. Emroch of Richmond; J. Samuel Glasscock of Suffolk; George H. Heilig, Jr. of Norfolk; Thomas J. Michie, Jr. of Charlottesville; Richard L. Saslaw of Annandale; Alson H. Smith, Jr. of Winchester; Erwin S. Soloman of Hot Springs; W. Ward Teel of Christiansburg; and S. Vance Wilkins, Jr. of Amherst.

The Joint Subcommittee to Study Hospice held public hearings in Richmond and in Falls Church to solicit input on hospice. A number of individuals spoke to the Joint Subcommittee and offered to provide advisory assistance to the legislative study. Consequently, a technical committee was formed to assist the Joint Subcommittee in defining the legislative issues to be addressed to facilitate the establishment of hospice care in the Commonwealth.

The Joint Subcommittee to Study Hospice would like to take this opportunity to express its sincere appreciation to the volunteer services of the members of the technical committee who devoted invaluable time and expertise to research available data and to formulate recommendations for the provision of hospice in Virginia.

The members of the technical committee and the agencies or organizations represented by each member follow:

William F. Egelhoff, Medical College of Virginia, Department of Gerontology

William G. Flourney, Bureau of Insurance, State Corporation Commission

Ray L. Hemness, Virginia Hospital Association

Dr. Shelton Horsley, III, Chairman, Cancer Committee of the Virginia Medical Society

Patricia Kawana, Virginia Health Care Association

Edward M. Kelly, Northern Virginia Health Systems Agency

Dr. Josefina Magno, Hospice of Northern Virginia, Incorporated

Caroline Martin, Riverside Hospital, Newport News, Virginia

Dr. Susan Mellette, Medical College of Virginia - Virginia Commonwealth University Cancer Rehabilitation Program

Jeffry Staples, Saint Mary's Hospital, Richmond, Virginia

Fred Overstreet, Central Virginia Health Systems Agency

Edward C. Peple, Jr., Blue Cross and Blue Shield

William R. Shands, Jr., The Life Insurance Company of Virginia

Shelia Rosser, American Cancer Society

Katharine Webb, Virginia Department of Health

Edwin L. Wood, Virginia Office on Aging

The Joint Subcommittee to Study Hospice and the technical commitee members outlined the following areas to be considered in the hospice study:

1. the development of a working definition of hospice

2. licensure requirements and the feasibility of including hospice under the State Certificate of Need Law

3. reimbursement for hospice services by Medicare and Medicaid, Blue Cross and Blue Shield and other third party payors.

The technical committee divided into three task forces to study each of the areas of concern outlined above. The following findings and recommendations reflect the research and conclusions of the task forces.

FINDINGS

A. Definition

The following definition of hospice is offered as a compendium to delimit the various settings of hospice and the concepts to be embodied in any hospice program:

"'Hospice' means a coordinated program of home and in-patient care which treats the terminally ill[1] patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the physical, psychological, social, economic and other special needs which are experienced during the final stages of illness, and during dying and bereavement."[2]

It must be noted that the concept of hospice, relatively new in the United States, aims to foster the appropriate care of dying patients in their own homes through a program which coordinates home health care with in-patient services. In-patient hospice services offered in either a free-standing facility, a hospital or a nursing home are to be utilized only in cases where hospice home care is inappropriate or unavailable to the patient diagnosed as terminally ill.

B. Licensure and Certificate of Need

The unique nature of hospice which emphasizes the appropriate level of care rather than the establishment of new institutions or health care facilities makes the task of individuals who are responsible for the licensure of health care facilities and programs increasingly difficult. According to John Hackley, chairman of a national committee studying reimbursement and licensure for the National Hospice Organization, "Licensure that is hospice-focused is in the main nonexistant in the United States."[3] Guidelines for licensure requirements of hospice and standards for accreditation are being studied currently by the National Hospice Organization In addition, Joseph A. Califano, Secretary of the United States Department of Health, Education and Welfare, has offered to assist states in the evaluation of data provided in a variety of geographic locations and health care settings. Criteria for licensure and standards of care are among the data subject to evaluation under Secretary Califano's proposal.[4]

Additional data from currently operating hospice programs is needed to determine the statutory classification under which hospice may be licensed most appropriately, for example, whether hospice providers should be required to seek separate facility licensure, licensure as a home health agency, licensure as a skilled nursing facility or licensure under another classification.

To assure adequate planning of hospice programs and the provision of only the home care and in-patient services which can be demonstrated justifiable in terms of public need, the task force studying licensure and certificate-of-need as well as the task force studying reimbursement agree that providers of hospice care should be required to submit a certificate of need application to the State Department of Health.

The Virginia Code Commission will introduce to the 1979 Session of the General Assembly a proposed recodification of Title 32 of the Code of Virginia. As a part of the recodification, the

definition of "project" under the Virginia Certificate of Public Need statute is amended to delete the capital expenditure requirement from the part of the definition concerning the introduction of a new service (See Appendix D). The Office of the Attorney General of Virginia has advised the Joint Subcommittee to Study Hospice that the effect of the amendment to the definition of "project" (§ 32-211.5 of the Code of Virginia) is to require both a pre-existing medical facility which institutes a hospice program or a non-institutionally based hospice program to submit a certificate of need application. The introduction of a new service in any medical care facility would require a certificate of need whether or not a capital expenditure is involved. Consequently, the above concerns of the task forces would be addressed by the proposed recodification.

C. Reimbursement

"Since the hospice concept involves inpatient confinement, outpatient services, and home health care..., liability may exist under comprehensive and major medical expense type policies for services which can be identified as covered. For example, the services of physicians, physical and/or speech therapists, registered nurses, or even social workers may be covered. It is unlikely that the inpatient portion would be covered under existing hospital coverage unless, of course, the facility is licensed as a legally constituted hospital. There is a possibility that a hospice will have obtained skilled nursing home status and, where applicable, such benefits would be payable. It is also possible the hospice will have attained the status of a home health agency, and where home health care coverage exists, benefits would be allowed accordingly."[5]

Consequently, reimbursement for hospice services is dependent to a significant degree on the licensure classification of hospice. Decisions regarding reimbursement hinge on the findings concerning licensure.

The reimbursement task force of the technical committee identified a number of limitations on coverage for home health care and in-patient services offered by hospice providers. The current coverage available under the policies of the Life Insurance Company of Virginia, Blue Cross and Blue Shield and the Medicare program was analyzed in relation to the identified limitations.

The task force concluded that the most logical approach to addressing reimbursement for hospice services is to initiate a study to evaluate hospice programs in the State. The evaluation should be designed to provide reliable cost data on hospice services offered in a variety of geographic areas, administered by a variety of health care providers and serving a variety of patients who have been diagnosed terminally ill (i.e., not exclusively cancer patients). In view of the current State and national emphasis on cost containment for health care, analysis of the cost benefits of hospice care versus acute care should be a component of the study. The study should coordinate data regarding third-party reimbursement which is currently available for hospice services as well as identifying gaps in coverage and the costs of reimbursing for those gaps in services.

D. Demonstration Projects

The announcement by the United States Department of Health, Education and Welfare to conduct demonstration projects with organizations providing hospice services evidenced the growing national interest in the provision of hospice care to the terminally ill.

The proposal, outlined by Secretary Joseph A. Califano at the October, 1978 meeting of the National Hospice Organization, invites agencies and facilities which provide hospice home care only or both hospice home care and in-patient care to apply for participation in the demonstration projects which will allow coverage and reimbursement for hospice services provided to Medicare beneficiaries. Individual states must apply to the Department of Health, Education and Welfare for the waiver of requirements under the Medicaid program.

Some of the objectives of the demonstration projects and the evaluation process are:

1. To identify the levels of care and range of services provided by hospice in the home and in-patient settings.

2. To evaluate hospice in various settings as an alternative service and delivery system for the care of the terminally ill.

3. To evaluate the comparative costs of ospice services provided in different settings and varying hospice modes.

4. To develop standards regarding appropriateness and quality of care.

5. To identify alternate reimbursement methods.

6. To assess the appropriate role of various utilization review mechanisms.

7. To compare and assess hospice services with those provided in hospital and skilled nursing facilities.

8. To determine the affect of hospice on costs for Medicare, Medicaid and the costs of other providers.

9. To determine changes in the health care delivery system due to the availability of hospice to Medicare and Medicaid beneficiaries.

10. To record patient, family and physician attitudes toward hospice services. [6]

RECOMMENDATIONS

The Joint Subcommittee to Study Hospice in accordance with the findings and recommendations of the technical committee recommends that the Department of Health be requested to conduct a two-year evaluative study of hospice programs throughout Virginia to provide data and to make recommendations to the General Assembly regarding legislative action to facilitate the provision of hospice services in the Commonwealth. Criteria for standards defining appropriateness and quality of care and for licensure of hospice programs including both the home care and in-patient components should be investigated. Reliable cost data regarding reimbursement for hospice services which are not covered under current third party reimbursement policies, in addition to alternative reimbursement methods should be examined in the study. Comparisons of various health care settings of hospice and the appropriateness of services provided to the patient and his family should be reviewed. The Department of Health is encouraged to coordinate its study of hospice with the evaluation being conducted under the direction of the United States Department of Health, Education and Welfare and to encourage providers of hospice programs throughout the Commonwealth to apply with HEW for participation as demonstration projects.

The Joint Subcommitee supports the efforts of the Department of Health to apply for the waiver of necessary Medicaid requirements by the United States Department of Health, Education and Welfare to assist hospice programs in providing services to Medicaid eligible patients in the State.

Finally, in view of the progress made by the work of the technical committee comprised of providers of hospice programs, health planners, representatives of third party payors and interested citizens, the Joint Subcommittee to Study Hospice encourages the ongoing communication and discussion in the development of future efforts to meet the needs of terminally ill patients and their families.

Respectively submitted,

Mary A. Marshall

Gerald L. Baliles

David G. Brickley

Vincent F. Callahan, Jr.

Walter H. Emroch

J. Samuel Glasscock

George H. Heilig, Jr.

Thomas J. Michie, Jr.

Richard L. Saslaw

Alson H. Smith, Jr.

Erwin S. Solomon

* W. Ward Teel

S. Vance Wilkins, Jr.

* Comment by Delegate W. Ward Teel (next page).

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

W. WARD TEEL
P. O. BOX 509
CHRISTIANSBURG, VIRGINIA 24073

SIXTH DISTRICT
CARROLL, FLOYD,
MONTGOMERY AND THE CITY
OF RADFORD

COMMITTEE ASSIGNMENTS:
CORPORATIONS, INSURANCE AND BANKING
HEALTH, WELFARE AND INSTITUTIONS
LABOR AND COMMERCE
MINING AND MINERAL RESOURCES

January 26, 1979

The Honorable Mary A. Marshall, Chairman
Joint Subcommittee to Study Hospice
Room 453
General Assembly Building
Richmond, Virginia 23219

Dear Mary:

I am in general agreement with the report of the Joint Subcommittee to Study Hospice. However, I take exception with the report as it is stated on page nine, beginning with line 16 and extending to page ten through line 14.

I am not in agreement with the content to this particular section and, therefore, wish to express my opposition to that portion being included in the report.

Sincerely,

W. Ward Teel

WWT/ap

FOOTNOTES

[1] Terminally ill: diagnosed by a physician as having six months or less to live.

[2] Senate Bill No. 9725-B of the State of New York, passed during the 1978 Session of the Assembly of New York and signed by the Governor of the State of New York.

[3] Hackley, John A., President, Hillhaven foundation, Takoma, Washington, Chairman, National Hospice Organization Committee on Reimbursement and Licensure, speech before the National Hospice Organization Meeting, October 6, 1978, Shoreham Americana Hotel, Washington, D. C.

[4] Califano, Joseph A., Secretary, United States Department of Health, Education and Welfare, speech before the National Hospice Organization Meeting, October 5, 1978, Shoreham Americana Hotel, Washington, D. C.

[5] Jones, Donald D., Associate Director of Research, Health Insurance Association of America, "Health Insurance and Hospice Care", draft report to the Comprehensive Coverage Subcommittee, July 24, 1978, New York, p. 8.

[6] Department of Health, Education and Welfare, Health Care Financing Administration, Medicare and Medicaid Hospice Projects, issued October 6, 1978.

APPENDIX A

HOUSE JOINT RESOLUTION NO. 252

Requesting the Department of Health to study hospice programs and to apply for the waiver of necessary Medicaid requirements to facilitate the study.

WHEREAS, "hospice" is a coordinated program of home and in-patient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration; in addition, the program provides palliative and supportive care to meet the physical, psychological, social, economic and other special needs which are experienced during the final stages of illness, and during dying and bereavement; and

WHEREAS, the Joint Subcommittee to study Hospice has concluded that further study of hospice programs throughout the Commonwealth is needed to provide reliable data regarding standards of care, criteria for licensure, reimbursement policies and the appropriateness of various hospice programs; and

WHEREAS, the United States Department of Health, Education and Welfare is administering a similar nationwide study of hospice programs and, upon requests from the states, has agreed to waive certain Medicaid requirements perceived to hinder the provision of hospice care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Health is requested to conduct an evaluative study of hospice programs in Virginia and to make recommendations regarding standards for the quality of care, criteria for licensure and reimbursement of both the home care and in-patient components of hospice programs provided in a variety of health care settings and geographic areas of the State. The Department of Health is encouraged to coordinate its study with the evaluation being administered by the United States Department of Health, Education and Welfare; and, be it

RESOLVED FURTHER, That the Department of Health is requested to apply for the waiver of necessary Medicaid requirements by the United States Department of Health, Education and Welfare to assist hospice programs in providing services to Medicaid eligible patients.

The Department of Health is requested to present an interim report to the Governor and to the nineteen hundred eighty Session of the General Assembly and a final report to the Governor and the nineteen hundred eighty-one Session of the General Assembly.

APPENDIX B

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

MARY A. MARSHALL
2256 N. WAKEFIELD STREET
ARLINGTON, VIRGINIA 22207

TWENTY-SECOND DISTRICT
ARLINGTON

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
ROADS AND INTERNAL NAVIGATION
COUNTIES, CITIES AND TOWNS
HEALTH, WELFARE AND INSTITUTIONS

November 22, 1978

Honorable J. Marshall Coleman
Attorney General of Virginia
Supreme Court Building
4th Floor
Richmond, Virginia 23219

Dear Mr. Coleman:

The Joint Subcommittee to Study Hospice of the House of Delegates Committees on Health, Welfare and Institutions and Corporations, Insurance and Banking is studying necessary changes in State laws and regulations to establish hospices in Virginia. Based upon its studies and deliberations, the Joint Subcommittee has adopted a tentative definition of hospice: "Hospice" means a coordinated program of home and inpatient care which treats the terminally ill patient and family as a unit, employing an interdisciplinary team acting under the direction of an autonomous hospice administration. The program provides palliative and supportive care to meet the physical, psychological, social,-economic and other special needs which are experienced during the final stages of illness, and during dying and bereavement.

The Joint Subcommittee to Study Hospice has been assisted in its work by a technical committee comprising providers of hospice programs, health planners, representatives of third party payors and others. The findings and recommendations of the technical committee and Joint Subcommittee are embodied in the enclosed draft report of the Joint Subcommittee to Study Hospice to the 1979 Session of the General Assembly.

Among the recommendations being considered by the Joint Subcommittee is the inclusion of hospice program under the medical care facilities definition of the Virginia Medical Care Facilities Certificate of Public Need Law, Chapter 12.1 of Title 32 of the Code of Virginia. Legislation drafted to include the proposed amendment is enclosed.

There is some question among the members of the Joint Subcommittee whether a hospice program, as defined and described in the report, is subject to the certificate of need process under existing law. The Joint Subcommittee would appreciate receiving your opinion in this matter at your earliest convenience. The Subcommittee's decision to recommend the proposed legislation to include hospice programs under the medical care facilities definition of the Certificate of Need Law is contingent upon your opinion.

Your consideration in the expedition of this matter will be sincerely appreciated.

Sincerely,

Mary Marshall

Mary A. Marshall
Chairman, Joint Subcommittee
to Study Hospice

MAM/gh
Enclosure

APPENDIX C

Commonwealth of Virginia

OFFICE OF THE ATTORNEY GENERAL
SUPREME COURT BUILDING
1101 EAST BROAD STREET
RICHMOND, VIRGINIA 23219
804-786-2071

MARSHALL COLEMAN
ATTORNEY GENERAL

December 22, 1978

The Honorable Mary A. Marshall
Member, House of Delegates
2256 North Wakefield Street
Arlington, Virginia 22207

Dear Delegate Marshall:

You have asked, on behalf of the joint subcommittee to study hospice, whether the establishment of a hospice program would require a certificate of public need. If not, your subcommittee is considering legislation which would require sponsors of hospice programs to obtain certificates before proceeding.

In my judgment, hospice programs may be considered a new service under the law's definition of "project." See § 32-211.5 of the Code of Virginia (1950), as amended. However, three difficulties are present with this definition. First, the definition of "project" states, in relevant part, that a project "shall mean a capital expenditure, which under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which ... (3) substantially changes the services of the facility with respect to which such expenditure is made." (Emphasis added.) My experience with this definition has been that prospective applicants have argued that projects which propose new services must be in some way connected with a pre-existing medical care facility. Under this approach, a new non-institutionally based hospice program would not be covered by the law because it is not changing the services of any facility. Fortunately, however, the circuit courts have not followed this approach once evidence is introduced that the State Health Commissioner has routinely required all new services of which he became aware to apply for a certificate. In this respect, the definition of "medical care facilities" in § 32-211.5(6) of the Code has been helpful because many of the facilities listed therein do not involve substantial capital expenditures, e.g., independent laboratories, or they may not be institutionally

based, e.g., home health agencies. Consequently, although the law is inartfully worded in its definition of "project," it has not posed an insurmountable problem to date, and presumably the definition could encompass a hospice program as a new service.

The second difficulty, however, is that the State Board of Health has defined "new service" in its regulations. That definition refers to a modality which is "diagnostic, therapeutic, rehabilitative, or preventive." See § 2.20 of the Virginia Medical Care Facilities Certificate of Public Need Regulations (January 2, 1978). The intention was to define the term broadly to cover all conceivable, new services. Nevertheless, as you point out in your letter, hospice is generally considered a palliative program, and, therefore, it may not fall within the Board's definition. While I believe an argument could be advanced that hospice does fall within the definition, the better approach is to have the State Board of Health to amend its regulation, and I shall so advise the State Health Commissioner.

The third problem, and perhaps the worst, relates to the capital expenditure prerequisite in the definition of project. As the definition reads now, any new service must involve a capital expenditure "which under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance ... ." If it does not, no certificate of public need is apparently required. The effect of this fact is that a pre-existing facility which institutes a hospice program or a non-institutionally based hospice program may argue that it requires no certificate because it had no capital expenditure. Bearing in mind that, the burden of proving the existence of a capital expenditure is upon the Commissioner, it would probably not be possible to obtain a temporary injunction unless the defendant gratuitously and inadvertently admitted that there had been a capital expenditure. Consequently, even though hospice can be considered a new service, the capital expenditure requirement may allow a hospice program to evade the spirit of the law.

While the problems could be alleviated somewhat by specifically including hospice programs in the definition of "medical care facilities," it strikes me that the more crucial definition is that of "project". Accordingly, your subcommittee may wish to consider the amendment of that definition. As you may also be aware, the Code Commission is introducing in the 1979 session of the General Assembly a recodification of title 32. As part of that recodification, the definition of "project" was amended to delete the capital expenditure requirement from the part of the definition concerning new services. I have attached that proposed amendment for your subcommittee's consideration and possible endorsement in your report.

With kindest regards, I remain

Sincerely,

Robert T. Adams
Assistant Attorney General

cc: James B. Kenley, M.D.
Edwin M. Brown, M.D.
Raymond O. Perry
Martha Johnson

4:26:142

APPENDIX D

Virginia Code Commission

Proposed Amendment To

§ 32-211.5 of the

Code of Virginia

§ 32-211.5. Definitions.—As used in this ~~chapter~~ *article* , unless the context indicates otherwise:

(1) [Repealed.]

(2) [Repealed.]

(3) "~~Board~~" ~~means the State Board of Health~~.

(4) "~~Commissioner~~" ~~means the State Health Commissioner~~.

(5) "~~Department~~" ~~means the State Department of Health~~.

~~(5a)~~ *1.* "Health Systems Agency" means an entity organized and operated as provided in § 1512 of United States Public Law 93-641 and designated as a health systems agency pursuant to § 1515 of United States Public Law *93-641* .

~~(6)~~ *2.* "Medical care facilities" means any institution, place, building, or agency, whether or not licensed or required to be licensed by the ~~State~~ Board ~~of Health~~ or the State Mental Health and Mental Retardation Board, *whether operated for profit or nonprofit and whether privately owned or operated or owned or operated by a local governmental unit, (i)* by or in which facilities are maintained, furnished, conducted, operated, or offered for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, whether medical or surgical, of two or more nonrelated mentally or physically sick or injured persons, or for the care of two or more nonrelated persons requiring or receiving medical, surgical or nursing attention or services as acute, chronic, convalescent, aged, physically disabled, or crippled ~~, including~~, *or (ii) which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. The term includes,* but *is* not limited to ~~,~~ *:*

a. general hospitals,

b. sanatorium *s* ~~,~~

c. sanitarium *s* ~~,~~

d. nursing home *s* ~~,~~

e. intermediate care ~~facility~~ *facilities* ~~,~~

f. extended care ~~facility~~ *facilities* ~~,~~

g. health maintenance organization *s* ~~,~~

h. mental hospital *s* ~~,~~

i. mental retardation *facilities* ~~facility and other related institutions and facilities, whether operated for profit or nonprofit, and whether privately owned or operated or owned or operated by a local governmental unit or which is the recipient of reimbursements from third party health insurance programs or prepaid medical service plans. The term shall also include intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts and~~

j. intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of alcoholics or drug addicts

k. independent laboratories

l. specialized centers or clinics developed for the provision of outpatient or ambulatory surgery, renal dialysis therapy, radiation therapy, computerized tomography (CT) scanning or other medical or surgical treatments requiring the utilization of equipment not usually associated with the provision of primary health services

m. home health agencies required to be licensed pursuant to *Article 6.* of Chapter ~~27~~ *5* of this title.

~~This~~ *The* term *"medical care facilities"* shall not include *:*

a. a physician's office ~~. Provided, however, the term "physician's office" shall not include independent laboratories or specialized centers or clinics developed for the provision of outpatient or ambulatory surgery, renal dialysis therapy, radiation therapy, computerized tomography (CT) scanning, or other medical or surgical treatments requiring the utilization of~~ *except when* equipment not usually associated with the provision of primary health services, the cost of which exceeds two hundred thousand dollars per unit of equipment or such greater amount as may be prescribed by the Board *, is purchased or leased by such physician .* ~~This term shall not include~~

b. a first aid station for emergency medical or emergency surgical treatment.

~~(7)~~ *3.* "Project" shall mean *(1)* a capital expenditure ~~,~~ which *,* under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which ~~(1)~~ exceeds one hundred fifty thousand dollars or (2) ~~changes~~ *an increase in* the bed capacity of the facility with respect to which such expenditure is made, or (3) ~~substantially changes the services of the facility with respect to which such expenditure is made~~ *the introduction of a new service*

~~(8)~~ *4.* "Statewide Health Coordinating Council" means the duly authorized Statewide health advisory agency established pursuant to § ~~1524 of United States Public Law 93-641~~ *Article 4 of Chapter 4 of this title .*

§ ..... . Regulations.—The Board may promulgate such regulations as it deems necessary to carry out the purposes of this article.