COUNCIL OF THE DISTRICT OF COLUMBIA
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CHRISTINA HENDERSON
Councilmember, At-Large
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Committee Member
Hospital and Health Equity
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Statement of Introduction on the
Certificate of Need Improvement Amendment Act of 2024
September 16, 2024

Today, along with Councilmembers Charles Allen, Anita Bonds, Janeese Lewis George, and Zachary Parker, I am introducing the Certificate of Need Improvement Amendment Act of 2024. This bill aims to strengthen and modernize the process through which a new institutional health service, or capital expenditure related to an existing medical/health asset, obtains a Certificate of Need (CON) from the State Health Planning and Development Agency (SHPDA) within DC Health. Although 35 states require CONs in some instances, the District's requirements are the third most extensive among U.S. states, covering 25 types of health care services. Many health care providers in the District cite the CON process as an obstacle to improving and expanding health care services for District residents, given the typical 6-9 month process and significant associated expenses. This bill aims to strike a balance between maintaining the benefits of the CON process, which include enforcing uncompensated care requirements and promoting health equity, and removing unnecessary and burdensome obstacles for health care institutions and providers.

The primary purpose of the CON process is to control the number of health care resources in a given area, by requiring hospitals and health care systems to demonstrate the public need for a new health care service, facility, or expenditure from the state before starting the project. Although research has never shown that CONs control or reduce health care spending, CONs are a primary tool for state governments to encourage health care services to be distributed equitably. In the case of the District, CONs are one tool for DC Health to encourage health care services in parts of the District with less access to health care, such as Wards 7 and 8. Additionally, CON programs enable state governments to enforce uncompensated care requirements, and are also one of the only tools for regulating corporate mergers and acquisitions, which have been shown to increase healthcare spending.

This bill proposes several improvements to the District's CON process:

1. **Exempt Telehealth:** The District is an outlier in its enforcement of the CON process, which was created to regulate the geographic distribution of brick-and-mortar health care services, for virtual provider networks and virtual telehealth platforms. The bill instead requires DC Health to create a registration process for these entities.
2. **Exempt office-based primary care and specialist practices:** Only 2 other states regulate primary care facilities under CON (NJ, KY) and only 2 other states regulate specialist

practices with no operating rooms (VA, GA, KY). This would align the District with other states and encourage more primary and specialist care services to locate in the District.

3. **Require biennial updates to the capital thresholds**: SHPDA currently has the authority to update the capital expenditure thresholds that would trigger a CON review on an annual basis, but this does not regularly occur. This bill would require SHPDA to update the thresholds every 2 years to accurately reflect inflation and other economic indicators.
4. **Exclude nonpatient care capital projects:** Currently, health care facilities must submit for CON review for capital projects not related to patient care, such as installing new elevators, garage improvements, and HVAC upgrades. These reviews can delay necessary repairs and upgrades and create unnecessary costs. This bill proposes exempting these types of nonpatient care projects.
5. **More flexible project timeline:** Currently, SHPDA imposes a uniform deadline of 3 years for CON approved capital projects. Facilities have had to restart the process when an active project is taking longer than expected. This bill proposes a more flexible approach to extend the timeline if the applicant is making good faith efforts to meet the schedule.
6. **Define "Group practice"**: Although the term "group practice" is used in the current D.C. Code, it is not a defined term, which has led to confusion about when a new health care facility must apply for a CON. This bill seeks to clearly define that term.
7. **Adjust threshold for number of beds:** Currently, SHPDA requires any facility changing its licensed bed capacity to obtain a CON if the change is by at least 10 beds or 10% of total beds, whichever is less. This bill proposes increasing the threshold to 10 beds or 20% of total beds, to avoid small facilities going through a lengthy CON process for small changes to their operations.

These proposed changes will encourage more health care facilities to enter and stay in the District, bringing more jobs and health care access to our residents. I look forward to working with my Council colleagues and other stakeholders to advance and pass this legislation.

Councilmember Charles Allen

Councilmember Christina Henderson

Councilmember Zachary Parker

Councilmember Janeese Lewis George

Councilmember Anita Bonds

A BILL

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To amend the Health Services Planning Program Re-establishment Act of 1996 to exempt from the certificate of need process digital-only telehealth platforms and providers and primary care and specialty care providers not affiliated with hospitals and medical schools, to define group practice and nonpatient care project, to remove the 3 year maximum on certificate of need applications for active projects, to require the State Health Planning and Development Agency to update the capital expenditure and medical equipment spending thresholds every two years, to increase the number of beds that must be added or removed at a health care facility in order to trigger a certificate of need, and to require the Department of Health to create a registration process for facilities offering primary and secondary care, virtual provider networks, and virtual telehealth platforms.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Certificate of Need Improvement Amendment Act of 2024."

Sec. 2. The Health Services Planning Program Re-establishment Act of 1996, effective April 9, 1997 (D.C. Law 11-191; D.C. Official Code § 44–401 *et seq.*), is amended as follows:

(a) Section 2 is amended as follows:

(1) Paragraph (3) is amended as follows:

(A) Subparagraph (A) is amended as follows:

(i) Sub-subparagraph (i) is amended by striking the phrase "SHPDA may, by rule, adjust this threshold annually" and inserting the phrase "SHPDA shall, by rule, adjust this threshold every 2 years" in its place.

(ii) Sub-subparagraph (ii) is amended by striking the phrase "SHPDA may, by rule, adjust this threshold annually" and inserting the phrase "SHPDA shall, by rule, adjust this threshold every 2 years" in its place.

(B) A new subparagraph (C) is added to read as follows:

"(C) The term "capital expenditure" does not include an expenditure on a nonpatient care project.".

(2) A new paragraph (9B) is added to read as follows:

"(9B) "Group practice" means:

"(A) A group of 2 or more health professionals, including a faculty practice plan, legally organized and authorized to do business in the District of Columbia, for which:

"(i) Each member of the group is licensed to practice in the District of Columbia and provides substantially the full range of services which the health professional routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment and personnel, except surgery as defined at D.C. Official Code § 44-501(13A);

"(ii) Substantially all of the services provided through the group are billed under a billing number assigned to the group and amounts received are treated as revenue of the group;

"(iii) The overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by group members;

"(iv) No member of the group directly or indirectly receives compensation based on the volume or value of referrals by the health professional; and

"(v) Members of the group personally conduct no less than 75 percent of the patient encounters of the group practice.

"(B) In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program, paragraph (A) of this section shall only apply to the services provided within the faculty practice plan.".

(3) Paragraph (10) is amended to read as follows:

"(10) "Health care facility" or "HCF" means any private general hospital, psychiatric hospital, other specialty hospital, rehabilitation facility, skilled nursing facility, intermediate care facility, ambulatory care center or clinic, ambulatory surgical facility, kidney disease treatment center, freestanding hemodialysis facility, diagnostic health care facility home health agency, hospice, or other comparable health care facility which has an annual operating budget of at least $500,000. The term "health care facility" shall not include the private office facilities, clinics, or other establishments with no operating rooms where a health professional or group of health professionals provides primary care services or specialty care services according to the applicable scope of practice defined by their licensure; a virtual provider network or virtual telehealth platform; or a health care facility licensed or to be licensed as a community residence facility, or an Assisted Living Residence as defined by section 201 of the Assisted

Living Residence Regulatory Act of 2000, effective June 24, 2000 (D.C. Law 13-127; D.C. Official Code § 44-102.01).".

(4) Paragraph (12) is amended by striking the phrase "services provided by physicians, dentists, HMOs, and other individual providers in individual or group practice." and inserting the phrase "services provided within private office facilities, clinics, or other establishments with no operating rooms where a health professional or group of health professionals provides primary care services or specialty care services according to the applicable scope of practice defined by their licensure, or services provided by a virtual provider network or accessed through a virtual telehealth platform." in its place.

(5) Paragraph (14)(A)(i) is amended by striking the phrase "SHPDA may, by rule, adjust this threshold annually" and inserting the phrase "SHPDA shall, by rule, adjust this threshold every 2 years" in its place.

(6) Paragraph (15) is amended as follows:

(A) Subparagraph (A) is amended as follows:

(i) Sub-subparagraph (iii) is amended by striking the phrase "Any new health service;" and inserting the phrase "Any new health service with a physical location;" in its place.

(ii) Sub-subparagraph (iv) is amended by striking the phrase "or 10%" and insert the phrase "or 20%" in its place.

(B) Subparagraph (B) is amended by striking the phrase "SHPDA may, by rule, adjust this threshold annually" and inserting the phrase "SHPDA shall, by rule, adjust this threshold every 2 years" in its place.

(7) A new paragraph (15A) is added to read as follows:

"(15A) "Nonpatient care project" means any capital project by a healthcare facility or a hospital that does not solely directly or indirectly impact clinical procedures, treatments, patient interactions, or clinical areas. Nonpatient care projects can include the construction or renovation of administrative offices; the purchase of non-medical equipment such as office furniture or IT systems; renovation or replacement of electrical, heating, cooling and ventilation systems; replacement or renovation of elevator and escalators or other means of ingress and egress; renovation or replacement of fire and life safety systems; and other initiatives focused solely on supporting the administrative functions of the facility.".

(8) New paragraphs (21) and (22) are added to read as follows:

"(21) "Virtual provider network" means a provider-owned and managed entity which employs or contracts with licensed health care providers, and which exclusively provides telehealth or telemedicine health care services through a virtual telehealth platform. The term "virtual provider network" does not mean an entity who maintains a physical facility, office, or other similar location in any jurisdiction where a person may go to seek care in person.

"(22) "Virtual telehealth platform" means a digital-only telehealth or telemedicine entity which facilitates the ability for District residents to access licensed health care providers by exclusively providing health care services through a virtual provider network. The term "virtual telehealth platform" does not mean an entity who maintains a physical facility, office, or other similar location in any jurisdiction where a person may go to seek care in person.".

(b) Section 3 is amended as follows:

(1) Subsection (b-1) is repealed.

(2) A new subsection b-2 is inserted to read as follows:

"(b-2)(1) The Director of the Department of Health shall create a registration process for facilities offering primary care and specialty care services, virtual provider networks, and virtual telehealth platforms operating in the District.

"(2) The registration process shall be consistent with and shall not create requirements more restrictive than those set forth in the provisions contained in this Act.".

(c) Section 8(b) is amended as follows:

(1) Paragraph (3) is amended by striking the phrase "requiring the obligation of a capital expenditure of less than $8 million;" and inserting a semicolon in its place.

(2) A new paragraph (21) is added to read as follows:

"(21) Any proposal by a virtual telehealth platform or virtual provider network to provide access to, offer, or develop health care services provided exclusively via a virtual telehealth platform and accessible by District of Columbia residents.".

(d) Section 12(a) is amended by striking the phrase "; except that no certificate of need shall be effective for more than 3 years from the original date of issuance." and inserting a period in its place.

Sec. 3. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 4a of the General Legislative Procedures Act of 1975, approved October 16, 2006 (120 Stat. 2038; D.C. Official Code § 1-301.47a).

Sec. 4. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), a 30-day period of congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December

153 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of
154 Columbia Register.