**Section 1250.1330 General Review Criteria**

In measuring or relating findings to the basic considerations in Section 1250.1320 the State Agency at a minimum must address the general conditions stated below in each appropriateness review:

a) The relationship of the health services being reviewed to the applicable health systems plans, annual implementation plans, and State health plan.

b) The relationship of the services reviewed to the institution's master plan (if required) of the person providing the services.

c) The current and future need the population served has for the services, and the extent to which low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups have access to those services.

d) The availability of less costly or more effective alternative methods of providing the services.

e) The relationship of the services reviewed to the existing health care system of the area in which the services are provided including the impact of and the need for multi-institutional arrangements.

f) The availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of the services reviewed and the availability of alternative uses of these resources for the provision of other health services.

g) The special needs and circumstances of those entitles which provide a substantial portion of their services or resources or both, to individuals not residing in the health service areas in which the entitles are located or in adjacent health service areas. These entitles may include medical and other health profession schools, multidisciplinary clinics, and specialty centers.

h) The special needs and circumstances of HMOs. In the case of areawide reviews which result in institution-specific findings regarding services provided by or through an HMO, the needs and circumstances shall be limited to:

1) The needs of enrolled members and reasonably anticipated new members of the HMO for the existing institutional health services provided by the organization.

2) Whether the services could be obtained from non-HMO, or other HMO, providers in a reasonable and cost-effective manner which is consistent with the basic method of operation of the HMO.

3) Any other factors which the State Agency may propose and the Secretary may, in accordance with paragraph (c) of this section, find to be consistent with the purpose of Title XIII of the Act.

i) The special needs and circumstances of biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

j) The contribution of the existing institutional health services in meeting the health related needs of members of medically underserved groups and groups which have traditionally experienced difficulties in obtaining equal access to health services (for example: low income persons, racial and ethnic minorities, women, handicapped persons) particularly those needs identified in the applicable health systems plan and annual implementation plan as deserving of priority.

k) The special circumstances of health service institutions with respect to the need for conserving energy.

l) In accordance with Section 1502(b) of the National Health Planning and Resources Development Act, the effect of compentition on the supply of the health services being reviewed.

m) Improvements or innovations in the financing and delivery of health services which foster competition, in accordance with Section 1502(b) of the National Health Planning and Resources Development Act, and serve to promote quality assurance and cost effectiveness.

n) The quality of care provided by the services or facilities in the past.

o) The number of years the service has been provided and the impact of start-up time on the appropriateness of the service.

p) The geographic area in which the service is located, including travel-time distance factors, and population density.