WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

Senate Bill 597

FISCAL NOTE

BY SENATORS FERNS AND PLYMALE

[Introduced February 12, 2016;

Referred to the Committee on Health and Human

Resources; and then to the Committee on Finance.]

A BILL to amend and reenact §5F-1-3a of the Code of West Virginia, 1931, as amended; to amend and reenact §6-7-2a of said code; to amend and reenact §9-4C-7 of said code; to amend and reenact §11-27-9 and §11-27-11 of said code; to amend and reenact §16-2D-2 and §16-2D-5 of said code; to amend and reenact §16-5F-2, §16-5F-3, §16-5F-4, §16-5F-5 and §16-5F-6 of said code; to amend and reenact §16-29B-3, §16-29B-5, §16-29B-6, §16-29B-7, §16-29B-8, §16-29B-9, §16-29B-11, §16-29B-12, §16-29B-13, §16-29B-14, §16-29B-15, §16-29B-17, §16-29B-18, §16-29B-19a, §16-29B-22, §16-29B-23, §16-29B-24, §16-29B-25 and §16-29B-26 of said code; to amend said code by adding thereto a new section, designated §16-29B-5a; to amend and reenact §16-29G-2, §16-29G-4, §16-29G-5 and §16-29G-6 of said code; and to amend and reenact §16-29I-4 of said code, all relating generally to the Health Care Authority; employment of the members of the Board of the West Virginia Health Care Authority; setting salaries for board members; creating the position of Executive Director of the Health Care Authority; making the executive director the administrative head of the Health Care Authority; setting forth the qualifications of the executive director; adding the executive director to the Public Employees Insurance Agency Advisory Board; clarifying where the administrative duties of the Health Care Authority are to be carried out; clarifying that the Board of Directors of the Health Care Authority is the adjudicatory arm of the Health Care Authority; requiring that the members of the board of directors be employed on a part-time basis; setting forth other employment requirements for the board of directors; expanding the board of directors from three to five members; setting forth qualifications for appointment to the board of directors; providing that the board of directors shall report to the executive director; establishing compensation for the board of directors; setting forth minimum hearing requirements before the board of directors; providing for recommended decisions by the board of directors to the executive director; setting forth executive director procedure for review and approval of recommended decisions of the board of directors; providing for remand of a decision;

clarifying that the executive director has all rule-setting powers; providing for a study by the Health Care Authority of concerns of hospitals in border counties; requiring a comprehensive study of the certificate of need program, including possible elimination of certificate of need; eliminating rate review from the authority of the Health Care Authority; making technical corrections; and updating code reference.

Be it enacted by the Legislature of West Virginia:

That §5F-1-3a of the Code of West Virginia, 1931, as amended, be amended and reenacted; that §6-7-2a of said code be amended and reenacted; that §9-4C-7 of said code be amended and reenacted; that §11-27-9 and §11-27-11 of said code be amended and reenacted; that §16-2D-2 and §16-2D-5 of said code be amended and reenacted; that §16-5F-2, §16-5F-3, §16-5F-4, §16-5F-5 and §16-5F-6 of said code be amended and reenacted; that §16-29B-3, §16-29B-5, §16-29B-6, §16-29B-7, §16-29B-8, §16-29B-9, §16-29B-11, §16-29B-12, §16-29B-13, §16-29B-14, §16-29B-15, §16-29B-17, §16-29B-18, §16-29B-19a, §16-29B-22, §16-29B-23, §16-29B-24, §16-29B-25 and §16-29B-26 of said code be amended and reenacted; that said code be amended by adding thereto a new section, designated §16-29B-5a; that §16-29G-2, §16-29G-4, §16-29G-5 and §16-29G-6 of said code be amended and reenacted; and that §16-29I-4 of said code be amended and reenacted, all to read as follows:

CHAPTER 5F. REORGANIZATION OF THE EXECUTIVE BRANCH OF STATE GOVERNMENT.

ARTICLE 1. GENERAL PROVISIONS.

§5F-1-3a. Executive compensation commission.

There is hereby created an executive compensation commission composed of three members, one of whom shall be the secretary of administration, one of whom shall be appointed by the Governor from the names of two or more nominees submitted by the President of the Senate, and one of whom shall be appointed by the Governor from the names of two or more

nominees submitted by the Speaker of the House of Delegates. The names of such nominees shall be submitted to the Governor by not later than June 1, 2000, and the appointment of such members shall be made by the Governor by not later than July 1, 2000. The members appointed by the Governor shall have had significant business management experience at the time of their appointment and shall serve without compensation other than reimbursement for their reasonable expenses necessarily incurred in the performance of their commission duties. For the 2001 regular session of the Legislature and every four years thereafter, the commission shall review the compensation for cabinet secretaries and other appointed officers of this state, including, but not limited to, the following: Commissioner, Division of Highways; commissioner, Bureau of Employment Programs; director, Division of Environmental Protection; commissioner, Bureau of Senior Services; director of tourism; commissioner, division of tax; administrator, division of health; commissioner, Division of Corrections; director, Division of Natural Resources; superintendent, State Police; administrator, Lottery Division; director, Public Employees Insurance Agency; administrator, Alcohol Beverage Control Commission; commissioner, Division of Motor Vehicles; director, Division of Personnel; Adjutant General; ~~chairman, Health Care Authority; members, Health Care Authority;~~ the Executive Director of the Health Care Authority; director, Division of Rehabilitation Services; executive director, Educational Broadcasting Authority; executive secretary, Library Commission; Chairman and members of the Public Service Commission; Director of Emergency Services; administrator, Division of Human Services; executive director, Human Rights Commission; director, Division of Veterans Affairs; director, Office of Miner's Health Safety and Training; commissioner, Division of Banking; commissioner, Division of Insurance; commissioner, Division of Culture and History; commissioner, Division of Labor; director, Prosecuting Attorneys Institute; director, Board of Risk and Insurance Management; commissioner, Oil and Gas Conservation Commission; director, Geological and Economic Survey; executive director, Water Development Authority; executive director, Public Defender Services; director, State Rail Authority; Chairman and members of the Parole Board;

members, Employment Security Review Board; members, Workers' Compensation Appeal Board; chairman, Racing Commission; executive director, Women's Commission; and director, Hospital Finance Authority.

Following this review, but not later than the twenty-first day of such regular session, the commission shall submit an executive compensation report to the Legislature to include specific recommendations for adjusting the compensation for the officers described in this section. The recommendation may be in the form of a bill to be introduced in each house to amend this section to incorporate the recommended adjustments.

CHAPTER 6. GENERAL PROVISIONS RESPECTING OFFICERS.

ARTICLE 7. COMPENSATION AND ALLOWANCES.

§6-7-2a. Terms of certain appointive state officers; appointment; qualifications; powers and salaries of officers.

(a) Each of the following appointive state officers named in this subsection shall be appointed by the Governor, by and with the advice and consent of the Senate. Each of the appointive state officers serves at the will and pleasure of the Governor for the term for which the Governor was elected and until the respective state officers' successors have been appointed and qualified. Each of the appointive state officers are subject to the existing qualifications for holding each respective office and each has and is hereby granted all of the powers and authority and shall perform all of the functions and services heretofore vested in and performed by virtue of existing law respecting each office.

The annual salary of each named appointive state officer is as follows:

Commissioner, Division of Highways, $92,500; Commissioner, Division of Corrections, $80,000; Director, Division of Natural Resources, $75,000; Superintendent, State Police, $85,000; Commissioner, Division of Banking, $75,000; Commissioner, Division of Culture and History, $65,000; Commissioner, Alcohol Beverage Control Commission, $75,000;

Commissioner, Division of Motor Vehicles, $75,000; ~~Chairman, Health Care Authority, $80,000; members, Health Care Authority, $70,000;~~ Director, Human Rights Commission, $55,000; Commissioner, Division of Labor, $70,000; prior to July 1, 2011, Director, Division of Veterans Affairs, $65,000; Chairperson, Board of Parole, $55,000; members, Board of Parole, $50,000; members, Employment Security Review Board, $17,000; and Commissioner, Workforce West Virginia, $75,000. Secretaries of the departments shall be paid an annual salary as follows: Health and Human Resources, $95,000: *Provided*, That effective July 1, 2013, the Secretary of the Department of Health and Human Resources shall be paid an annual salary not to exceed $175,000; Transportation, $95,000: *Provided, however*, That if the same person is serving as both the Secretary of Transportation and the Commissioner of Highways, he or she shall be paid $120,000; Revenue, $95,000; Military Affairs and Public Safety, $95,000; Administration, $95,000; Education and the Arts, $95,000; Commerce, $95,000; Veterans' Assistance, $95,000; and Environmental Protection,$95,000: *Provided further*, That any officer specified in this subsection whose salary is increased by more than $5,000 as a result of the amendment and reenactment of this section during the 2011 regular session of the Legislature shall be paid the salary increase in increments of $5,000 per fiscal year beginning July 1, 2011, up to the maximum salary provided in this subsection.

(b) Each of the state officers named in this subsection shall continue to be appointed in the manner prescribed in this code and shall be paid an annual salary as follows:

Director, Board of Risk and Insurance Management, $80,000; Director, Division of Rehabilitation Services, $70,000; Director, Division of Personnel, $70,000; Executive Director, Educational Broadcasting Authority, $75,000; Secretary, Library Commission, $72,000; Director, Geological and Economic Survey, $75,000; Executive Director, Prosecuting Attorneys Institute, $80,000; Executive Director, Public Defender Services, $70,000; Commissioner, Bureau of Senior Services, $75,000; Executive Director, Women's Commission, $45,000; Director, Hospital Finance Authority, $35,000; member, Racing Commission, $12,000; Chairman, Public Service

Commission, $85,000; members, Public Service Commission, $85,000; Director, Division of Forestry, $75,000; Director, Division of Juvenile Services, $80,000; and Executive Director, Regional Jail and Correctional Facility Authority, $80,000.

(c) Each of the following appointive state officers named in this subsection shall be appointed by the Governor, by and with the advice and consent of the Senate. Each of the appointive state officers serves at the will and pleasure of the Governor for the term for which the Governor was elected and until the respective state officers' successors have been appointed and qualified. Each of the appointive state officers are subject to the existing qualifications for holding each respective office and each has and is hereby granted all of the powers and authority and shall perform all of the functions and services heretofore vested in and performed by virtue of existing law respecting each office.

The annual salary of each named appointive state officer shall be as follows:

Commissioner, State Tax Division, $92,500; Insurance Commissioner, $92,500; Director, Lottery Commission, $92,500; Director, Division of Homeland Security and Emergency Management, $65,000; and Adjutant General, $125,000.

(d) No increase in the salary of any appointive state officer pursuant to this section may be paid until and unless the appointive state officer has first filed with the State Auditor and the Legislative Auditor a sworn statement, on a form to be prescribed by the Attorney General, certifying that his or her spending unit is in compliance with any general law providing for a salary increase for his or her employees. The Attorney General shall prepare and distribute the form to the affected spending units.

CHAPTER 9. HUMAN SERVICES.

ARTICLE 4C. HEALTH CARE PROVIDER MEDICAID ENHANCEMENT ACT.

§9-4C-7. Powers and duties.

(a) Each board created pursuant to this article shall:

(1) Develop, recommend and review reimbursement methodology where applicable, and develop and recommend a reasonable provider fee schedule, in relation to its respective provider groups, so that the schedule conforms with federal Medicaid laws and remains within the limits of annual funding available to the single state agency for the Medicaid program. In developing the fee schedule the board may refer to a nationally published regional specific fee schedule, if available, as selected by the secretary in accordance with section eight of this article. The board may consider identified health care priorities in developing its fee schedule to the extent permitted by applicable federal Medicaid laws, and may recommend higher reimbursement rates for basic primary and preventative health care services than for other services. In identifying basic primary and preventative health care services, the board may consider factors, including, but not limited to, services defined and prioritized by the basic services task force of the health care planning commission in its report issued in December of the year 1992; and minimum benefits and coverages for policies of insurance as set forth in section fifteen, article fifteen, chapter thirty-three of this code and section four, article sixteen-c of said chapter and rules of the Insurance Commissioner promulgated thereunder. If the single state agency approves the adjustments to the fee schedule, it shall implement the provider fee schedule;

(2) Review its respective provider fee schedule on a quarterly basis and recommend to the single state agency any adjustments it considers necessary. If the single state agency approves any of the board's recommendations, it shall immediately implement those adjustments and shall report the same to the Joint Committee on Government and Finance on a quarterly basis;

(3) Assist and enhance communications between participating providers and the Department of Health and Human Resources;

(4) Meet and confer with representatives from each specialty area within its respective provider group so that equity in reimbursement increases or decreases may be achieved to the greatest extent possible and when appropriate to meet and confer with other provider boards; and

(5) Appoint a chairperson to preside over all official transactions of the board.

(b) Each board may carry out any other powers and duties as prescribed to it by the secretary.

(c) Nothing in this section gives any board the authority to interfere with the discretion and judgment given to the single state agency that administers the state's Medicaid program. If the single state agency disapproves the recommendations or adjustments to the fee schedule, it is expressly authorized to make any modifications to fee schedules as are necessary to ensure that total financial requirements of the agency for the current fiscal year with respect to the state's Medicaid plan are met and shall report such modifications to the Joint Committee on Government and Finance on a quarterly basis. The purpose of each board is to assist and enhance the role of the single state agency in carrying out its mandate by acting as a means of communication between the health care provider community and the agency.

~~(d) In addition to the duties specified in subsection (a) of this section, the ambulance service provider Medicaid board shall work with the health care cost review authority to develop a method for regulating rates charged by ambulance services. The health care cost review authority shall report its findings to the Legislature by January 1, 1994. The costs of the report shall be paid by the health care cost review authority. In this capacity only, the chairperson of the health care cost review authority shall serve as an ex officio, nonvoting member of the board.~~

~~(e)~~(d) On a quarterly basis, the single state agency and the board shall report the status of the fund, any adjustments to the fee schedule and the fee schedule for each health care provider identified in section two of this article to the Joint Committee on Government and Finance.

CHAPTER 11. TAXATION.

ARTICLE 27. HEALTH CARE PROVIDER TAXES.

§11-27-9. Imposition of tax on providers of inpatient hospital services.

(a) *Imposition of tax*. -- For the privilege of engaging or continuing within this state in the business of providing inpatient hospital services, there is hereby levied and shall be collected from every person rendering such service an annual broad-based health care related tax: *Provided*, That ~~a hospital which meets all the requirements of section twenty-one, article twenty-nine-b, chapter sixteen of this code and regulations thereunder may change or amend its schedule of rates to the extent necessary to compensate for the tax in accordance with the following procedures:~~

~~(1) The health care cost review authority shall allow a temporary change in a hospital's rates which may be effective immediately upon filing and in advance of review procedures when a hospital files a verified claim that such temporary rate changes are in the public interest, and are necessary to prevent insolvency, to maintain accreditation or for emergency repairs or to relieve undue financial hardship. The verified claim shall state the facts supporting the hospital's position, the amount of increase in rates required to alleviate the situation and shall summarize the overall effect of the rate increase. The claim shall be verified by either the chairman of the hospital's governing body or by the chief executive officer of the hospital.~~

~~(2) Following receipt of the verified claim for temporary relief, the health care cost review authority shall review the claim through its usual procedures and standards; however, this power of review does not affect the hospital's ability to place the temporary rate increase into effect immediately. The review of the hospital's claim shall be for a permanent rate increase and the health care cost review authority may include such other factual information in the review as may be necessary for a permanent rate increase review. As a result of its findings from the permanent review, the health care cost review authority may allow the temporary rate increase to become permanent, to deny any increase at all, to allow a lesser increase, or to allow a greater increase.~~

~~(3) When any change affecting an increase in rates goes into effect before a final order is entered in the proceedings, for whatever reasons, where it deems it necessary and practicable, the health care cost review authority may order the hospital to keep a detailed and accurate~~

~~account of all amounts received by reason of the increase in rates and the purchasers and third-party payors from whom such amounts were received. At the conclusion of any hearing, appeal or other proceeding, the health care cost review authority may order the hospital to refund with interest to each affected purchaser and/or third-party payor any part of the increase in rates that may be held to be excessive or unreasonable. In the event a refund is not practicable, the hospital shall, under appropriate terms and conditions determined by the health care cost review authority, charge over and amortize by means of a temporary decrease in rates whatever income is realized from that portion of the increase in rates which was subsequently held to be excessive or unreasonable.~~

~~(4) The health care cost review authority, upon a determination that a hospital has overcharged purchasers or charged purchasers at rates not approved by the health care cost review authority or charged rates which were subsequently held to be excessive or unreasonable, may prescribe rebates to purchasers and third-party payors in effect by the aggregate total of the overcharge.~~

~~(5)~~ the rate adjustment provided ~~for~~ in this section is limited to a single adjustment during the initial year of the imposition of the tax provided for in this section.

(b) *Rate and measure of tax*. -- The tax imposed in subsection (a) of this section shall be two and one-half percent of the gross receipts derived by the taxpayer from furnishing inpatient hospital services in this state.

(c) Definitions. --

(1) "Gross receipts" means the amount received or receivable, whether in cash or in kind, from patients, third-party payors and others for inpatient hospital services furnished by the provider, including retroactive adjustments under reimbursement agreements with third-party payors, without any deduction for any expenses of any kind: *Provided*, That accrual basis providers shall be allowed to reduce gross receipts by their contractual allowances, to the extent such allowances are included therein, and by bad debts, to the extent the amount of such bad

debts was previously included in gross receipts upon which the tax imposed by this section was paid.

(2) "Contractual allowances" means the difference between revenue (gross receipts) at established rates and amounts realizable from third-party payors under contractual agreements.

(3) "Inpatient hospital services" means those services that are inpatient hospital services for purposes of Section 1903(w) of the Social Security Act.

(d) *Effective date*. -- The tax imposed by this section shall apply to gross receipts received or receivable by providers after May 31, 1993.

§11-27-11. Imposition of tax on providers of nursing facility services, other than services of intermediate care facilities for individuals with an intellectual disability.

(a) *Imposition of tax*. -- For the privilege of engaging or continuing within this state in the business of providing nursing facility services, other than those services of intermediate care facilities for individuals with an intellectual disability, there is levied and shall be collected from every person rendering such service an annual broad-based health care-related tax: *Provided*, That hospitals which provide nursing facility services may adjust nursing facility rates to the extent necessary to compensate for the tax: ~~without first obtaining approval from the Health Care Authority~~ *Provided, however*, That the rate adjustment is limited to a single adjustment during the initial year of the imposition of the tax ~~which adjustment is exempt from prospective review by the Health Care Authority~~ and further which is limited to an amount not to exceed the amount of the tax which is levied against the hospital for the provision of nursing facility services pursuant to this section. ~~The Health Care Authority shall retroactively review the rate increases implemented by the hospitals under this section during the regular rate review process. A hospital which fails to meet the criteria established by this section for a rate increase exempt from prospective review is subject to the penalties imposed under article twenty-nine-b, chapter sixteen of the code.~~

(b) *Rate and measure of tax*. -- The tax imposed in subsection (a) of this section is five and one-half percent of the gross receipts derived by the taxpayer from furnishing nursing facility

services in this state, other than services of intermediate care facilities for individuals with an intellectual disability. This rate shall be increased to five and seventy-two one hundredths percent of the gross receipts received or receivable by providers of nursing facility services on and after October 1, 2015, and shall again be decreased to five and one-half percent of the gross receipts received or receivable by providers of nursing services after June 30, 2016.

(c) *Definitions*. --

(1) "Gross receipts" means the amount received or receivable, whether in cash or in kind, from patients, third-party payors and others for nursing facility services furnished by the provider, including retroactive adjustments under reimbursement agreements with third-party payors, without any deduction for any expenses of any kind: Provided, That accrual basis providers are allowed to reduce gross receipts by their bad debts, to the extent the amount of those bad debts was previously included in gross receipts upon which the tax imposed by this section was paid.

(2) "Nursing facility services" means those services that are nursing facility services for purposes of §1903(w) of the Social Security Act.

(d) *Effective date*. -- The tax imposed by this section applies to gross receipts received or receivable by providers after May 31, 1993.

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-2. Definitions.

Definitions of words and terms defined in articles five-f and twenty-nine-b of this chapter are incorporated in this section unless this section has different definitions.

As used in this article, unless otherwise indicated by the context:

(a) "Affected person" means:

(1) The applicant;

(2) An agency or organization representing consumers;

(3) Any individual residing within the geographic area served or to be served by the applicant;

(4) Any individual who regularly uses the health care facilities within that geographic area;

(5) The health care facilities located within this state which provide services similar to the services of the facility under review and which will be significantly affected by the proposed project;

(6) The health care facilities located within this state which, before receipt by the state agency of the proposal being reviewed, have formally indicated an intention to provide similar services within this state in the future;

(7) Third-party payors who reimburse health care facilities within this state similar to those proposed for services;

(8) Any agency that establishes rates for health care facilities within this state similar to those proposed; or

(9) Organizations representing health care providers.

(b) "Ambulatory health care facility" means a free-standing facility that provides health care to noninstitutionalized and nonhomebound persons on an outpatient basis. For purposes of this definition, a free-standing facility is not located on the campus of an existing health care facility. This definition does not include any facility engaged solely in the provision of lithotripsy services or the private office practice of any one or more health professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code: *Provided*, That this exemption from review may not be construed to include practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: *Provided*, *however*, That this exemption from review may not be construed to include certain health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(c) "Ambulatory surgical facility" means a free-standing facility that provides surgical treatment to patients not requiring hospitalization. For purposes of this definition, a free-standing

facility is not physically attached to a health care facility. This definition does not include the private office practice of any one or more health professionals licensed to practice surgery in this state pursuant to the provisions of chapter thirty of this code: *Provided*, That this exemption from review may not be construed to include practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: *Provided, however*, That this exemption from review may not be construed to include health services otherwise subject to review under the provisions of subdivision (1), subsection (a), section four of this article.

(d)"Applicant" means: (1) The governing body or the person proposing a new institutional health service who is, or will be, the health care facility licensee wherein the new institutional health service is proposed to be located; and (2) in the case of a proposed new institutional health service not to be located in a licensed health care facility, the governing body or the person proposing to provide the new institutional health service. Incorporators or promoters who will not constitute the governing body or persons responsible for the new institutional health service may not be an applicant.

(e) "Bed capacity" means the number of beds licensed to a health care facility or the number of adult and pediatric beds permanently staffed and maintained for immediate use by inpatients in patient rooms or wards in an unlicensed facility.

(f) "Campus" means the adjacent grounds and buildings, or grounds and buildings not separated by more than a public right-of-way, of a health care facility.

(g) "Capital expenditure" means:

(1) An expenditure made by or on behalf of a health care facility, which:

(A) (i) Under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance; or (ii) is made to obtain either by lease or comparable arrangement any facility or part thereof or any equipment for a facility or part; and

(B)(i) Exceeds the expenditure minimum; (ii) is a substantial change to the bed capacity of the facility with respect to which the expenditure is made; or (iii) is a substantial change to the services of such facility;

(2) The donation of equipment or facilities to a health care facility, which if acquired directly by that facility would be subject to review;

(3) The transfer of equipment or facilities for less than fair market value if the transfer of the equipment or facilities at fair market value would be subject to review; or

(4) A series of expenditures, if the sum total exceeds the expenditure minimum and if determined by the state agency to be a single capital expenditure subject to review. In making this determination, the state agency shall consider: Whether the expenditures are for components of a system which is required to accomplish a single purpose; whether the expenditures are to be made over a two-year period and are directed towards the accomplishment of a single goal within the health care facility’s long-range plan; or whether the expenditures are to be made within a two-year period within a single department such that they will constitute a significant modernization of the department.

(h) "Expenditure minimum" means $2,700,000 for the calendar year 2009. The state agency shall adjust the expenditure minimum annually and publish an update of the amount on or before December 31, of each year. The expenditure minimum adjustment shall be based on the DRI inflation index published in the *Global Insight DRI/WEFA Health Care Cost Review*, or its successor or appropriate replacement index. This amount shall include the cost of any studies, surveys, designs, plans, working drawings, specifications and other activities, including staff effort and consulting and other services essential to the acquisition, improvement, expansion or replacement of any plant or equipment.

(i) "Health", used as a term, includes physical and mental health.

(j) "Health care facility" means a publicly or privately owned facility, agency or entity that offers or provides health care services, whether a for-profit or nonprofit entity and whether or not licensed, or required to be licensed, in whole or in part, and includes, but is not limited to, hospitals; skilled nursing facilities; kidney disease treatment centers, including free-standing hemodialysis units; intermediate care facilities; ambulatory health care facilities; ambulatory surgical facilities; home health agencies; hospice agencies; rehabilitation facilities; health

maintenance organizations; and community mental health and intellectual disability facilities. For purposes of this definition, "community mental health and intellectual disability facility" means a private facility which provides such comprehensive services and continuity of care as emergency, outpatient, partial hospitalization, inpatient or consultation and education for individuals with mental illness, intellectual disability or drug or alcohol addiction.

(k)"Health care provider" means a person, partnership, corporation, facility, hospital or institution licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical, remedial or behavioral health care, treatment or confinement.

(l) "Health maintenance organization" means a public or private organization which:

(1) Is required to have a certificate of authority to operate in this state pursuant to section three, article twenty-five-a, chapter thirty-three of this code; or

(2) (A) Provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: Usual physician services, hospitalization, laboratory, X ray, emergency and preventive services and out-of-area coverage;

(B) Is compensated except for copayments for the provision of the basic health care services listed in paragraph (A) of this subdivision to enrolled participants on a predetermined periodic rate basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent or kind of health service actually provided; and

(C) Provides physicians' services: (i) Directly through physicians who are either employees or partners of the organization; or (ii) through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

(m) "Health services" means clinically related preventive, diagnostic, treatment or rehabilitative services, including alcohol, drug abuse and mental health services.

(n) "Home health agency" means an organization primarily engaged in providing professional nursing services either directly or through contract arrangements and at least one of the following services: Home health aide services, other therapeutic services, physical therapy,

speech therapy, occupational therapy, nutritional services or medical social services to persons in their place of residence on a part-time or intermittent basis.

(o) "Hospice agency" means a private or public agency or organization licensed in West Virginia for the administration or provision of hospice care services to terminally ill persons in the persons' temporary or permanent residences by using an interdisciplinary team, including, at a minimum, persons qualified to perform nursing services; social work services; the general practice of medicine or osteopathy; and pastoral or spiritual counseling.

(p) "Hospital" means a facility licensed as such pursuant to the provisions of article five-b of this chapter, and any acute care facility operated by the state government, that primarily provides inpatient diagnostic, treatment or rehabilitative services to injured, disabled or sick persons under the supervision of physicians and includes psychiatric and tuberculosis hospitals.

(q) "Intermediate care facility" means an institution that provides health-related services to individuals with mental or physical conditions that require services above the level of room and board, but do not require the degree of services provided in a hospital or skilled-nursing facility.

(r) "Long-range plan" means a document formally adopted by the legally constituted governing body of an existing health care facility or by a person proposing a new institutional health service which contains the information required by the state agency in rules adopted pursuant to section eight of this article.

(s) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used for the provision of medical and other health services and costs in excess of $2,700,000 in the calendar year 2009. The state agency shall adjust the dollar amount specified in this subsection annually and publish an update of the amount on or before December 31, of each year. The adjustment of the dollar amount shall be based on the DRI inflation index published in the *Global Insight DRI/WEFA Health Care Cost Review* or its successor or appropriate replacement index. This term does not include 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 Title XVIII of the Social Security Act to meet the requirements of paragraphs ten and eleven, Section 1861(s) of such act, Title 42 U.S.C. §1395x. In determining whether medical equipment is major medical equipment, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition of such equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

(t) "Medically underserved population" means the population of an area designated by the state agency as having a shortage of personal health services. The state agency may consider unusual local conditions that are a barrier to accessibility or availability of health services. The designation shall be in rules adopted by the state agency pursuant to section eight of this article, and the population so designated may include the state’s medically underserved population designated by the federal Secretary of Health and Human Services under Section 330(b)(3) of the Public Health Service Act, as amended, Title 42 U.S.C. §254.

(u) "New institutional health service" means any service as described in section three of this article.

(v) "Nonhealth-related project" means a capital expenditure for the benefit of patients, visitors, staff or employees of a health care facility and not directly related to preventive, diagnostic, treatment or rehabilitative services offered by the health care facility. This includes, but is not limited to, chapels, gift shops, news stands, computer and information technology systems, educational, conference and meeting facilities, but excluding medical school facilities, student housing, dining areas, administration and volunteer offices, modernization of structural components, boiler repair or replacement, vehicle maintenance and storage facilities, parking facilities, mechanical systems for heating, ventilation systems, air conditioning systems and loading docks.

(w) "Offer", when used in connection with health services, means that the health care facility or health maintenance organization holds itself out as capable of providing, or as having the means to provide, specified health services.

(x) "Person" means an individual, trust, estate, partnership, committee, corporation, association and other organizations such as joint-stock companies and insurance companies, a state or a political subdivision or instrumentality thereof or any legal entity recognized by the state.

(y)"Physician" means a doctor of medicine or osteopathy legally authorized to practice by the state.

(z) "Proposed new institutional health service" means any service as described in section three of this article.

(aa) "Psychiatric hospital" means an institution that primarily provides to inpatients, by or under the supervision of a physician, specialized services for the diagnosis, treatment and rehabilitation of mentally ill and emotionally disturbed persons.

(bb) "Rehabilitation facility" means an inpatient facility 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.

(cc) "Review agency" means an agency of the state, designated by the Governor as the agency for the review of state agency decisions.

(dd) "Skilled nursing facility" means an institution, or a distinct part of an institution, that primarily provides inpatient skilled nursing care and related services, or rehabilitation services, to injured, disabled or sick persons.

(ee) "State agency" means the Health Care Authority created, established and continued pursuant to article twenty-nine-b of this chapter. <u>The Executive Director as set forth in section three, article twenty-nine-b of this chapter, is the administrative head of the Health Care Authority.</u>

(ff) "State health plan" means the document approved by the Governor after preparation by the former statewide health coordinating council or that document as approved by the Governor after amendment by the former health care planning council or the state agency.

(gg) "Substantial change to the bed capacity" of a health care facility means any change, associated with a capital expenditure, that increases or decreases the bed capacity or relocates beds from one physical facility or site to another, but does not include a change by which a health

care facility reassigns existing beds as swing beds between acute care and long-term care categories: *Provided*, That a decrease in bed capacity in response to federal rural health initiatives is excluded from this definition.

(hh)"Substantial change to the health services" of a health care facility means: (1) The addition of a health service offered by or on behalf of the health care facility which was not offered by or on behalf of the facility within the twelve-month period before the month in which the service is first offered; or (2) the termination of a health service offered by or on behalf of the facility: *Provided*, That “substantial change to the health services” does not include the providing of ambulance service, wellness centers or programs, adult day care or respite care by acute care facilities.

(ii) "To develop", when used in connection with health services, means to undertake those activities which upon their completion will result in the offer of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service.

§16-2d-5. Powers. Powers and duties of state agency.

(a) The state agency shall administer the certificate of need program as provided by this article.

(b) The state agency is responsible for coordinating and developing the health planning research efforts of the state and for amending and modifying the state health plan which includes the certificate of need standards. The state agency shall review the state health plan, including the certificate of need standards and make any necessary amendments and modifications. The state agency shall also review the cost effectiveness of the certificate of need program. The state agency may form task forces to assist it in addressing these issues. The task forces shall be composed of representatives of consumers, business, providers, payers and state agencies.

(c) The state agency may seek advice and assistance of other persons, organizations and other state agencies in the performance of the state agency’s responsibilities under this article.

(d) For health services for which competition appropriately allocates supply consistent with the state health plan, the state agency shall, in the performance of its functions under this article,

give priority, where appropriate to advance the purposes of quality assurance, cost effectiveness and access, to actions which would strengthen the effect of competition on the supply of the services.

(e) For health services for which competition does not or will not appropriately allocate supply consistent with the state health plan, the state agency shall, in the exercise of its functions under this article, take actions, where appropriate to advance the purposes of quality assurance, cost effectiveness and access and the other purposes of this article, to allocate the supply of the services.

(f) Notwithstanding the provisions of section seven of this article, the state agency may charge a fee for the filing of any application, the filing of any notice in lieu of an application, the filing of any exemption determination request or the filing of any request for a declaratory ruling. The fees charged may vary according to the type of matter involved, the type of health service or facility involved or the amount of capital expenditure involved: *Provided*, That any fee charged pursuant to this subsection may not exceed a dollar amount to be established by procedural rule. The state agency shall evaluate and amend any procedural rule promulgated prior to the amendments to this subsection made during the 2009 regular session of the Legislature. The fees charged shall be deposited into a special fund known as the Certificate of Need Program Fund to be expended for the purposes of this article.

(g) A hospital, nursing home or other health care facility may not add any intermediate care or skilled nursing beds to its current licensed bed complement. This prohibition also applies to the conversion of acute care or other types of beds to intermediate care or skilled nursing beds: *Provided*, That hospitals eligible under the provisions of section four-a of this article and subsection (i) of this section may convert acute care beds to skilled nursing beds in accordance with the provisions of these sections, upon approval by the state agency. Furthermore, a certificate of need may not be granted for the construction or addition of any intermediate care or skilled nursing beds except in the case of facilities designed to replace existing beds in unsafe existing facilities. A health care facility in receipt of a certificate of need for the construction or

addition of intermediate care or skilled nursing beds which was approved prior to the effective date of this section shall incur an obligation for a capital expenditure within twelve months of the date of issuance of the certificate of need. Extensions may not be granted beyond the twelve-month period. The state agency shall establish a task force or utilize an existing task force to study the need for additional nursing facility beds in this state. The study shall include a review of the current moratorium on the development of nursing facility beds; the exemption for the conversion of acute care beds to skilled nursing facility beds; the development of a methodology to assess the need for additional nursing facility beds; and certification of new beds both by Medicare and Medicaid. The task force shall be composed of representatives of consumers, business, providers, payers and government agencies.

(h) No additional intermediate care facility for individuals with an intellectual disability (ICF/ID) beds may be granted a certificate of need, except that prohibition does not apply to ICF/MR beds approved under the Kanawha County circuit court order of August 3, 1989, civil action number MISC-81-585 issued in the case of E.H. v. Matin, 168 W.V. 248, 284 S.E. 2d 232 (1981).

(i) Notwithstanding the provisions of subsection (g) of this section and further notwithstanding the provisions of subsection (b), section three of this article, an existing acute care hospital may apply to the Health Care Authority for a certificate of need to convert acute care beds to skilled nursing beds: *Provided*, That the proposed skilled nursing beds are Medicare certified only: *Provided, however*, That any hospital which converts acute care beds to Medicare certified only skilled nursing beds shall not bill for any Medicaid reimbursement for any converted beds. In converting beds, the hospital shall convert a minimum of one acute care bed into one Medicare-certified only skilled nursing bed. The Health Care Authority may require a hospital to convert up to and including three acute care beds for each Medicare-certified only skilled nursing bed: *Provided further*, That a hospital designated or provisionally designated by the state agency as a rural primary care hospital may convert up to thirty beds to a distinct-part nursing facility, including skilled nursing beds and intermediate care beds, on a one-for-one basis if the rural primary care hospital is located in a county without a certified freestanding nursing facility and the

hospital may bill for Medicaid reimbursement for the converted beds: *And provided further*, That if the hospital rejects the designation as a rural primary care hospital, then the hospital may not bill for Medicaid reimbursement. The Health Care Authority shall adopt rules to implement this subsection which require that:

(1) All acute care beds converted shall be permanently deleted from the hospital's acute care bed complement and the hospital may not thereafter add, by conversion or otherwise, acute care beds to its bed complement without satisfying the requirements of subsection (b), section three of this article for which purposes an addition, whether by conversion or otherwise, shall be considered a substantial change to the bed capacity of the hospital notwithstanding the definition of that term found in subsection (ff), section two of this article.

(2) The hospital shall meet all federal and state licensing certification and operational requirements applicable to nursing homes including a requirement that all skilled care beds created under this subsection shall be located in distinct-part, long-term care units.

(3) The hospital shall demonstrate a need for the project.

(4) The hospital shall use existing space for the Medicare-certified only skilled nursing beds. Under no circumstances shall the hospital construct, lease or acquire additional space for purposes of this section.

(5) The hospital shall notify the acute care patient, prior to discharge, of facilities with skilled nursing beds which are located in or near the patient's county of residence. Nothing in this subsection negatively affects the rights of inspection and certification which are otherwise required by federal law or regulations or by this code or duly adopted rules of an authorized state entity.

(j) (1) Notwithstanding the provisions of subsection (g) of this section, a retirement life care center with no skilled nursing beds may apply to the Health Care Authority for a certificate of need for up to sixty skilled nursing beds provided the proposed skilled beds are Medicare-certified only. On a statewide basis, a maximum of one hundred eighty skilled beds which are Medicare-certified only may be developed pursuant to this subsection. The state health plan is not applicable to

projects submitted under this subsection. The Health Care Authority shall adopt rules to implement this subsection which shall include a requirement that:

(A) The one hundred eighty beds are to be distributed on a statewide basis;

(B) There be a minimum of twenty beds and a maximum of sixty beds in each approved unit;

(C) The unit developed by the retirement life care center meets all federal and state licensing certification and operational requirements applicable to nursing homes;

(D) The retirement center demonstrates a need for the project;

(E) The retirement center offers personal care, home health services and other lower levels of care to its residents; and

(F) The retirement center demonstrates both short- and long-term financial feasibility.

(2) Nothing in this subsection negatively affects the rights of inspection and certification which are otherwise required by federal law or regulations or by this code or duly adopted rules of an authorized state entity.

(k) The state agency may order a moratorium upon the offering or development of a new institutional health service when criteria and guidelines for evaluating the need for the new institutional health service have not yet been adopted or are obsolete. The state agency may also order a moratorium on the offering or development of a health service, notwithstanding the provisions of subdivision (5), subsection (b), section three of this article, when it determines that the proliferation of the service may cause an adverse impact on the cost of health care or the health status of the public. A moratorium shall be declared by a written order which shall detail the circumstances requiring the moratorium. Upon the adoption of criteria for evaluating the need for the health service affected by the moratorium, or one hundred eighty days from the declaration of a moratorium, whichever is less, the moratorium shall be declared to be over and applications for certificates of need are processed pursuant to section six of this article: *Provided*, That the state agency may not order a moratorium upon the offering or development of skilled nursing facilities providing services for the treatment of children under one year of age suffering from

Neonatal Abstinence Syndrome.

(l) (1) The state agency shall coordinate the collection of information needed to allow the state agency to develop recommended modifications to certificate of need standards as required in this article. When the state agency proposes amendments or modifications to the certificate of need standards, it shall file with the Secretary of State, for publication in the State Register, a notice of proposed action, including the text of all proposed amendments and modifications, and a date, time and place for receipt of general public comment. To comply with the public comment requirement of this section, the state agency may hold a public hearing or schedule a public comment period for the receipt of written statements or documents.

(2) When amending and modifying the certificate of need standards, the state agency shall identify relevant criteria contained in section six of this article or rules adopted pursuant to section eight of this article and apply those relevant criteria to the proposed new institutional health service in a manner that promotes the public policy goals and legislative findings contained in section one of this article. In doing so, the state agency may consult with or rely upon learned treatises in health planning, recommendations and practices of other health planning agencies and organizations, recommendations from consumers, recommendations from health care providers, recommendations from third-party payors, materials reflecting the standard of care, the state agency's own developed expertise in health planning, data accumulated by the state agency or other local, state or federal agency or organization and any other source deemed relevant to the certificate of need standards proposed for amendment or modification.

(3) All proposed amendments and modifications to the certificate of need standards, with a record of the public hearing or written statements and documents received pursuant to a public comment period, shall be presented to the Governor. Within thirty days of receiving the proposed amendments or modifications, the Governor shall either approve or disapprove all or part of the amendments and modifications and, for any portion of amendments or modifications not approved, shall specify the reason or reasons for nonapproval. Any portions of the amendments or modifications not approved by the Governor may be revised and resubmitted.

(4) The certificate of need standards adopted pursuant to this section which are applicable to the provisions of this article are not subject to article three, chapter twenty-nine-a of this code. The state agency shall follow the provisions set forth in this subsection for giving notice to the public of its actions, holding hearings or receiving comments on the certificate of need standards. The certificate of need standards in effect on November 29, 2005, and all prior versions promulgated and adopted in accordance with the provisions of this section are and have been in full force and effect from each of their respective dates of approval by the Governor.

(m) The state agency may exempt from or expedite, ~~rate review~~ certificate of need and annual assessment requirements and issue grants and loans to financially vulnerable health care facilities located in underserved areas that the state agency and the Office of Community and Rural Health Services determine are collaborating with other providers in the service area to provide cost effective health care services.

ARTICLE 5F. HEALTH CARE FINANCIAL DISCLOSURE.

§16-5F-2. Definitions.

As used in this article:

(1) "Annual report" means an annual financial report for the covered facility's or related organization's fiscal year prepared by an accountant or the covered facility's or related organization's Auditor.

(2) ~~"Board"~~ "Authority" means the West Virginia Health Care Authority.

(3) "Covered facility" means any hospital, skilled nursing facility, kidney disease treatment center, including a free-standing hemodialysis unit; intermediate care facility; ambulatory health care facility; ambulatory surgical facility; home health agency; hospice agency; rehabilitation facility; health maintenance organization; or community mental health or intellectual disability facility, whether under public or private ownership or as a profit or nonprofit organization and whether or not licensed or required to be licensed, in whole or in part, by the state: *Provided*, That nonprofit, community-based primary care centers providing primary care services without

regard to ability to pay which provide the ~~board~~ authority with a year-end audited financial statement prepared in accordance with generally accepted auditing standards and with governmental auditing standards issued by the Comptroller General of the United States shall be deemed to have complied with the disclosure requirements of this section.

(4) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a covered facility through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners, including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For the purposes of this subdivision "family members" shall mean brothers and sisters whether by the whole or half blood, spouse, ancestors and lineal descendants.

(5) "Rates" means all rates, fees or charges imposed by any covered facility for health care services.

(6) "Records" includes accounts, books, charts, contracts, documents, files, maps, papers, profiles, reports, annual and otherwise, schedules and any other fiscal data, however recorded or stored.

§16-5F-3. General powers and duties of the board regarding reporting and review.

(a) In addition to the powers granted to the ~~board~~ authority elsewhere in this article, the ~~board~~ authority shall have the powers as indicated by this section and it shall be its duty to:

(1) Promulgate legislative rules ~~and regulations~~ in accordance with the provisions of article three, chapter twenty-nine-a of this code, to implement and make effective the powers, duties and responsibilities contained in the provisions of this article.

(2) Require the filing of fiscal information by covered facilities and related organizations relating to any matter affecting the cost of health care services in this state.

(3) Exercise, subject to the limitations and restrictions herein imposed, all other powers which are reasonably necessary or essential to carry out the expressed purposes of this article.

(4) Require the filing of copies of all tax returns required by federal and state law to be filed by covered facilities and related organizations.

(b) The ~~board~~ authority shall also investigate and recommend to the Legislature whether other health care providers should be made subject to the provisions of this article.

(c) The ~~board~~ authority shall, not later than December 31 of each year, prepare and transmit to the Governor and to the clerks of both houses of the Legislature a report containing the material and data as required by section four of this article, based upon the most recent data available.

~~The board shall, no later than July 1, 1992, prepare and transmit to the Governor and to the clerks of both houses of the Legislature a special report containing the material and data collected on related organizations. The report shall further explain the effect of the financial activities of the related organizations as represented by the collected data and its relationship to the rate setting powers of the board specified in section nineteen, article twenty-nine-b of this chapter~~

§16-5F-4. Reports required to be published and filed; form of reports; right of inspection.

(a) Every covered facility and related organization defined in this article, within one hundred twenty days after the end of each of their fiscal years, unless an extension be granted by the ~~board~~ authority for good cause shown, shall be required to file with the ~~board~~ authority and publish, as a Class I legal advertisement, pursuant to section two, article three, chapter fifty-nine of the Code of West Virginia, in a qualified newspaper published within the county within which such covered facility or related organization is located, an annual report prepared by the covered facility's or related organization's Auditor or an independent accountant.

Such report shall contain a complete statement of the following:

(1) Assets and liabilities;

(2) Income and expenses;

(3) Profit or loss for the period reported;

(4) A statement of ownership for persons owning more than five percent of the capital stock outstanding and the dividends paid thereon, if any, and to whom paid for the period reported unless the covered facility or related organization be duly registered on the New York stock

exchange, American stock exchange, any regional stock exchange, or its stock traded actively over the counter. Such statement shall further contain a disclosure of ownership by any parent company or subsidiary, if applicable.

Such annual report shall also include a prominent notice that the details concerning the contents of the advertisement, together with the other reports, statements and schedules required to be filed with the ~~board~~ authority by the provisions of this section, shall be available for public inspection and copying at the board's office.

(b) Every covered facility and related organization shall also file with the ~~board~~ authority the following statements, schedules or reports in such form and at such intervals as may be specified by the ~~board~~ authority, but at least annually:

(1) A statement of services available and services rendered;

(2) A statement of the total financial needs of such covered facility or related organization and the resources available or expected to become available to meet such needs;

(3) A complete schedule of such covered facility's or related organization's then current rates with costs allocated to each category of costs, in accordance with the rules ~~and regulations~~ as promulgated by the ~~board~~ authority pursuant to section three hereof;

(4) A copy of such reports made or filed with the federal health care financing administration, or its successor, as the ~~board~~ authority may deem necessary or useful to accomplish the purposes of this article;

(5) A statement of all charges, fees or salaries for goods or services rendered to the covered facility or related organization for the period reported which shall exceed in total the sum of $55,000 and a statement of all charges, fees or other sums collected by the covered facility or related organization for or on the account of any person, firm, partnership, corporation or other entity, however structured, which shall exceed in total the sum of $55,000 during the period reported;

(6) Such other reports of the costs incurred in rendering services as the ~~board~~ authority may prescribe. The ~~board~~ authority may require the certification of specified financial reports by

the covered facility's or related organization's auditor or independent accountant; and

(7) A copy of all tax returns required to be filed by federal and state law.

(c) Notwithstanding any provision to the contrary herein, any data or material that is furnished to the ~~board~~ authority pursuant to the provisions of subdivision (4), subsection (b) of this section need not be duplicated by any other requirements of this section requiring the filing of data and material.

(d) No report, statement, schedule or other filing required or permitted to be filed hereunder shall contain any medical or individual information personally identifiable to a patient or a consumer of health services, whether directly or indirectly. All such reports, statements and schedules filed with the ~~board~~ authority under this section shall be open to public inspection and shall be available for examination during regular hours. Copies of such reports shall be made available to the public upon request and the ~~board~~ authority may establish fees reasonably calculated to reimburse the ~~board~~ authority for its actual costs in making copies of such reports: *Provided*, That all tax returns filed pursuant to this article shall be confidential and it shall be unlawful for the ~~board~~ authority or any member of its staff to divulge or make known in any manner the tax return, or any part thereof, of any covered facility or related organization.

(e) Whenever further fiscal information is deemed necessary to verify the accuracy of any information set forth in any statement, schedule or report filed by a covered facility or related organization under the provisions of this article, the ~~board~~ authority shall have the authority to require the production of any records necessary to verify such information.

(f) From time to time, the ~~board~~ authority shall engage in or carry out analyses and studies relating to health care costs, the financial status of any covered facility or related organization or any other appropriate related matters, and make determinations of whether, in its opinion, the rates charged by a covered facility are economically justified.

§16-5F-5. Injunctions.

Whenever it appears that any covered facility or related organization, required to file or publish such reports, as provided in this article, has failed to file or publish such reports, the

Attorney General, upon the request of the ~~board~~ authority, may apply in the name of the state to, and the circuit court of the county in which such covered facility or related organization is located shall have jurisdiction for the granting of a mandatory injunction to compel compliance with the provisions of this article.

§16-5F-6. Failure to make, publish or distribute reports; penalty; appeal to Supreme Court of Appeals.

Every covered facility and related organization failing to make and transmit to the ~~board~~ authority any of the reports required by law or failing to publish or distribute the reports as so required, shall forthwith be notified by the ~~board~~ authority and, if such failure continues for ten days after receipt of said notice, such delinquent facility or organization shall be subject to a penalty of $1,000 for each day thereafter that such failure continues, such penalty to be recovered by the ~~board~~ authority through the Attorney General in a civil action and paid into the State Treasury to the account of the General Fund. Review of any final judgment or order of the circuit court shall be by appeal to the West Virginia Supreme Court of Appeals.

ARTICLE 29B. HEALTH CARE AUTHORITY.

§16-29B-3. Definitions.

Definitions of words and terms defined in articles two-d and five-f of this chapter are incorporated in this section unless this section has different definitions.

As used in this article, unless a different meaning clearly appears from the context:

(a) “Authority” means the Health Care Authority created pursuant to the provisions of this article, a division within the State Department of Health and Human Resources;

(b) "Board" means the five-member board of directors of the West Virginia Health Care Authority;

~~(a)~~(c) "Charges" means the economic value established for accounting purposes of the goods and services a hospital provides for all classes of purchasers;

~~(b)~~(d) "Class of purchaser" means a group of potential hospital patients with common

characteristics affecting the way in which their hospital care is financed. Examples of classes of purchasers are Medicare beneficiaries, welfare recipients, subscribers of corporations established and operated pursuant to article twenty-four, chapter thirty-three of this code, members of health maintenance organizations and other groups as defined by the ~~board~~ authority

~~(c) "Board" means the three-member board of directors of the West Virginia Health Care Authority, an autonomous division within the State Department of Health and Human Resources~~;

(e) Executive Director" or "Director" means the Executive Director who is the administrative head of the Health Care Authority as set forth in section five-a of this article;

~~(d)~~(f) "Health care provider" means a person, partnership, corporation, facility, hospital or institution licensed, certified or authorized by law to provide professional health care service in this state to an individual during this individual's medical, remedial, or behavioral health care, treatment or confinement. For purposes of this article, "health care provider" shall not include the private office practice of one or more health care professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code;

~~(e)~~(g) "Hospital" means a facility subject to licensure as such under the provisions of article five-b of this chapter, and any acute care facility operated by the state government which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, and does not include state mental health facilities or state long-term care facilities;

~~(f)~~(h) "Person" means an individual, trust, estate, partnership, committee, corporation, association or other organization such as a joint stock company, a state or political subdivision or instrumentality thereof or any legal entity recognized by the state;

~~(g)~~(i) "Purchaser" means a consumer of patient care services, a natural person who is directly or indirectly responsible for payment for such patient care services rendered by a health care provider, but does not include third-party payers;

~~(h)~~(j) "Rates" means all value given or money payable to health care providers for health care services, including fees, charges and cost reimbursements;

~~(i)~~(k) "Records" means accounts, books and other data related to health care costs at health care facilities subject to the provisions of this article which do not include privileged medical information, individual personal data, confidential information, the disclosure of which is prohibited by other provisions of this code and the laws enacted by the federal government, and information, the disclosure of which would be an invasion of privacy;

(l) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a health care provider through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For the purposes of this subsection family members shall mean brothers and sisters, whether by the whole or half blood, spouse, ancestors and lineal descendants; and

~~(j)~~(m) "Third-party payor" means any natural person, person, corporation or government entity responsible for payment for patient care services rendered by health care providers.

~~(k) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a health care provider through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For the purposes of this subsection family members shall mean brothers and sisters, whether by the whole or half blood, spouse, ancestors and lineal descendants.~~

§16-29B-5. West Virginia Health Care Authority; composition of the board; qualifications; terms; oath; expenses of members; vacancies; appointment of chairman, and meetings of the board.

~~The "West Virginia Health Care Cost Review Authority" is continued as an autonomous division of the Department of Health and Human Resources and shall be known as~~ The "West Virginia Health Care Authority" is continued and reassigned as a division of the Department of Health and Human Resources and is hereinafter referred to as the ~~"board"~~ "authority". The Board of Directors of the West Virginia Health Care Authority shall hereinafter be referred to as the

"board". Any references in this code to the West Virginia health care cost review authority means the West Virginia Health Care Authority.

(a) The board shall consist of ~~three~~ five members, appointed by the Governor, with the advice and consent of the Senate. The members of the board shall be employed on a part time basis. The board members shall not be permitted to hold political office in the government of the state either by election or appointment while serving as a member of the board. The board members shall not be eligible for civil service coverage as provided in section four, article six, chapter twenty-nine of this code. The board members shall be citizens and residents of this state. No more than ~~two~~ three of the board members may be members of the same political party. One board member shall have a background in health care finance or economics, one board member shall have previous employment experience in human services, business administration or substantially related fields, one board member shall have previous experience in the administration of a health care facility, one board member shall have previous experience as a provider of health care services, and one board member shall be a consumer of health services with a demonstrated interest in health care issues.

(b) Each board member shall, before entering upon the duties of his or her office, take and subscribe to the oath provided by section five, article IV of the Constitution of the State of West Virginia, which oath shall be filed in the office of the Secretary of State. ~~The Governor shall designate one of the board members to serve as chairman at the Governor's will and pleasure. The chairman shall be the chief administrative officer of the board~~

(c) The Governor may remove any board member only for incompetency, neglect of duty, gross immorality, malfeasance in office or violation of the provisions of this article. Appointments are for terms of six years, except that an appointment to fill a vacancy shall be for the unexpired term only.

~~(c)~~(d) No person while in the employ of, or holding any official relation to, any hospital or health care provider subject to the provisions of this article, or who has any pecuniary interest in any hospital or health care provider, may serve as a member of the board or as an employee of

the board. Nor may any board member be a candidate for or hold public office or be a member of any political committee while acting as a board member; nor may any board member or employee of the board receive anything of value, either directly or indirectly, from any third-party payor or health care provider. If any of the board members become a candidate for any public office or for membership on any political committee, the Governor shall remove the board member from the board and shall appoint a new board member to fill the vacancy created. No board member or former board member may accept employment with any hospital or health care provider subject to the jurisdiction of the board in violation of the West Virginia governmental ethics act, chapter six-b of this code: *Provided*, That the act shall not apply to employment accepted after termination of the board.

~~(d)~~(e) The concurrent judgment of two of the board members when in session as the board shall be considered the action of the board. A vacancy in the board shall not affect the right or duty of the remaining board members to function as a board.

(f) The board is under the direct supervision of the Executive Director. The Executive Director shall serve as the *ex officio, nonvoting* chair of the board. The board shall serve as the adjudicatory body of the authority and shall conduct all hearings as required in this article, article two-d of this chapter and any other hearing as required by this code or any legislative or procedural rule of the authority. The Executive Director shall act as hearing examiner for all hearings before the board.

(g) The board shall advise the Executive Director created in section five-a of this article on matters relative to the administration of the authority. This shall include contracting authority, staffing, rulemaking and data collection and interpretation.

(h) Board members are entitled to receive from the authority's funds as compensation for his or her services an annual salary of $15,000. Board members shall also be reimbursed from the authority's funds for sums necessary to carry out its responsibilities and for reasonable travel expenses to attend meetings.

§16-29B-5a. Executive Director of the Health Care Authority; powers and duties.

(a) The Governor, with advice and consent of the Senate, shall appoint an individual as Executive Director of the Health Care Authority. This person shall oversee the daily operation of the Health Care Authority. This person shall be qualified by training and experience to direct the operations of the Health Care Authority. The Executive Director is ineligible for civil service coverage as provided in section four, article six, chapter twenty-nine of this code and serves at the will and pleasure of the Governor.

(b) The Executive Director shall:

(1) Serve on a full time basis and may not be engaged in any other profession or occupation;

(2) Not hold political office in the government of the state either by election or appointment while serving as Executive Director;

(3) Shall be a citizen of the United States and shall become a citizen of the state within ninety days of appointment;

(4) Shall be paid a salary as set by the Governor;

(5) Report to the Secretary of the Department of Health and Human Resources; and

(6) Before entering upon the duties of his or her office, take and subscribe to the oath provided by section five, article IV of the Constitution of the State of West Virginia, which oath shall be filed in the office of the Secretary of State.

(c) The Executive Director has other powers and duties as set forth in this article.

§16-29B-6. Information gathering and coordination; data advisory group.

(a) The Executive Director with advice from the board shall: Coordinate and oversee the health data collection of state agencies; lead state agencies' efforts to make the best use of emerging technology to effect the expedient and appropriate exchange of health care information and data, including patient records and reports; and coordinate database development, analysis and reporting to facilitate cost management, utilization review and quality assurance efforts by state payor and regulatory agencies, insurers, consumers, providers and other interested parties. Agencies of the state collecting health data shall work together through the ~~board~~ Executive

Director to develop an integrated system for the efficient collection, responsible use and dissemination of such data and to facilitate and support the development of statewide health information systems that will allow for the electronic transmittal of all health information and claims processing activities of state agencies within the state and that will coordinate the development and use of electronic health information systems within state government. The Executive Director with advice from the board shall establish minimum requirements and issue reports relating to information systems of all state health programs, including simplifying and standardizing forms, establishing information standards and reports for capitated managed care programs to be managed by the ~~Insurance Commission~~ Office of the Insurance Commissioner, and shall develop a comprehensive system to collect ambulatory health care data. The ~~board~~ Executive Director or his or her designee is authorized to gain access to any health-related database in state government for the purposes of fulfilling its duties: *Provided*, That, for any database to which the ~~board~~ Executive Director gains access, the use and dissemination of information from the database shall be subject to the confidentiality provisions applicable to such database.

(b) To advise the Executive Director and the board in its efforts under this section, the ~~board~~ Executive Director or his or her designee shall create a data advisory group. ~~and appoint one of the board's members as chair of the group~~ The Executive Director or his or her designee shall be the chair of the group. The group shall be composed of representatives of consumers, businesses, providers, payors and state agencies. At least one of the members shall represent the interest of hospitals which are regulated by the Health Care Authority. The data advisory group shall assist the Executive Director and the board in developing priorities and protocols for data collection and the development and reform of health information systems provided under this section.

(c) The ~~board's~~ staff of the Health Care Authority shall gather information on cost containment efforts, including, but not limited to, the provision of alternative delivery systems, prospective payment systems, alternative rate-making methods, and programs of consumer education. The ~~board~~ authority shall pay particular attention to the economic, quality of care and

health status impact of such efforts on purchasers or classes of purchasers, particularly the elderly and those on low or fixed incomes.

(d) The ~~board~~ authority staff shall further gather information on state-of-the-art advances in medical technology, the cost effectiveness of such advances and their impact on advances in health care services and management practices, and any other state-of-the-art concepts relating to health care cost containment, health care improvement or other issues the ~~board~~ authority finds relevant and directs staff to investigate. The ~~board~~ authority staff shall prepare and keep a register of such information and update it on an annual basis.

(e) The data advisory group members shall be reimbursed from the ~~board~~ authority's funds for sums necessary to carry out its responsibilities and for reasonable travel expenses to attend meetings.

§16-29B-7. Staff.

(a) The Executive Director with advice from the board may employ such persons as may be necessary to effect the provisions of this article. The Executive Director with advice from the board shall set the respective salaries or compensations of all staff. Any person employed by the ~~board~~ Health Care Authority other than on a part-time basis shall devote full time to the performance of his or her duties as such employee during the regular working hours of the ~~board~~ authority.

(b) The ~~board~~ Executive Director shall appoint general counsel who shall act as legal counsel to the Executive Director and the board. The general counsel shall serve at the will and pleasure of the ~~board~~ Executive Director and is not eligible for civil service coverage as provided in section four, article six, chapter twenty-nine of this code.

(1) The general counsel may act to bring and to defend actions on behalf of the authority and the board in the courts of the state and in federal courts.

(2) In all adjudicative matters before the board, the general counsel shall ~~advise~~ present the matter before the board and offer legal and administrative advice to the board. The staff shall represent itself in all such actions before the board.

(c) The ~~board~~ Executive Director may contract with third parties, including state agencies, for any services that may be necessary to perform the duties imposed upon ~~it~~ him or her by this article where such contractual agreements will promote economy, avoid duplication of effort or make the best use of available expertise.

(d) The Executive Director with advice from the board shall identify which members of the staff of the health care cost review authority shall be exempted from the salary schedules or pay plan adopted by the state personnel board, and further identify such staff members by job classification or designation, together with the salary or salary ranges for each such job classification or designation. This information shall be filed by the ~~board~~ Executive Director or his or her designee with the director of the Division of Personnel no later than July 1, 1991, ~~and thereafter as necessary~~ of every year as necessary.

§16-29B-8. Powers generally; budget expenses of the Executive Director and the board.

(a) In addition to the powers granted to the ~~board~~ Executive Director elsewhere in this article, the Executive Director with advice from the board may:

(1) Adopt, amend and repeal necessary, appropriate and lawful policy guidelines, ~~and~~ legislative rules promulgated in accordance with article three, chapter twenty-nine-a of this code and any procedural rules of the authority: *Provided,* That subsequent amendments and modifications to any legislative rule promulgated pursuant to this article and not exempt from the provisions of article three, chapter twenty-nine-a of this code may be implemented by emergency rule;

(2) Hold public hearings, conduct investigations and require the filing of information relating to matters affecting the costs of health care services subject to the provisions of this article and may subpoena witnesses, papers, records, documents and all other data in connection therewith. The board, who serves as the adjudicatory arm of the authority, may administer oaths or affirmations in any hearing or investigation;

(3) Apply for, receive and accept gifts, payments and other funds and advances from the United States, the state or any other governmental body, agency or agencies or from any other

private or public corporation or person (with the exception of hospitals subject to the provisions of this article, or associations representing them, doing business in the State of West Virginia, except in accordance with subsection (c) of this section), and enter into agreements with respect thereto, including the undertaking of studies, plans, demonstrations or projects. Any such gifts or payments that may be received or any such agreements that may be entered into shall be used or formulated only so as to pursue legitimate, lawful purposes of the ~~board~~ authority, and shall in no respect inure to the private benefit of the Executive Director, a board member, staff member, donor or contracting party;

(4) Lease, rent, acquire, purchase, own, hold, construct, equip, maintain, operate, sell, encumber and assign rights or dispose of any property, real or personal, consistent with the objectives of the ~~board~~ authority as set forth in this article: *Provided,* That such acquisition or purchase of real property or construction of facilities shall be consistent with planning by the state building commissioner and subject to the approval of the Legislature;

(5) Contract and be contracted with and execute all instruments necessary or convenient in carrying out the ~~board's~~ authority's functions and duties; and

(6) Exercise, subject to limitations or restrictions herein imposed, all other powers which are reasonably necessary or essential to effect the express objectives and purposes of this article.

(b) The Executive Director with advice from the board shall annually prepare a budget for the next fiscal year for submission to the Governor and the Legislature which shall include all sums necessary to support the activities of the Executive Director, board and ~~its staff~~ staff of the authority.

(c) Each hospital subject to the provisions of this article shall be assessed by the Executive Director with the advice of the board on a pro rata basis using the net patient revenue, as defined under generally accepted accounting principles, of each hospital as reported under the authority of section eighteen of this article as the measure of the hospital's obligation. The amount of such fee shall be determined by the Executive Director with the advice of the board except that in no case shall the hospital's obligation exceed one tenth of one percent of its net patient revenue.

Such fees shall be paid on or before the first day of July in each year and shall be paid into the State Treasury and kept as a special revolving fund designated "Health Care Cost Review Fund", with the moneys in such fund being expendable after appropriation by the Legislature for purposes consistent with this article. Any balance remaining in said fund at the end of any fiscal year shall not revert to the treasury, but shall remain in said fund and such moneys shall be expendable after appropriation by the Legislature in ensuing fiscal years.

(d) Each hospital's assessment shall be treated as an allowable expense by the ~~board~~ authority.

(e) The ~~board~~ authority is empowered to withhold ~~rate approvals,~~ certificates of need and rural health system loans and grants if any such fees remain unpaid, unless exempted under subsection (g), section four, article two-d of this chapter.

§16-29B-9. Annual report.

The ~~board~~ Executive Director shall, within thirty days of the close of the fiscal year, or from time to time as requested by the Legislature, prepare and transmit to the Governor and the Legislative Oversight commission on health and human resources accountability a report of its operations and activities for the preceding fiscal year. This report shall include summaries of all reports made by the hospitals subject to this article, together with facts, suggestions and policy recommendations the ~~board~~ authority considers necessary. ~~The board shall, after rate review and determination in accordance with the provisions of this article, include such rate schedules in its annual report or other reports as may be requested by the Legislature.~~

§16-29B-11. Related programs.

In addition to carrying out its duties under this article, the ~~board~~ authority shall carry out its information disclosure functions set forth in article five-f of this chapter and its functions set forth in article two-d of this chapter, including health planning, issuing grants and loans to financially vulnerable health care entities located in underserved areas, and the review and approval or disapproval of capital expenditures for health care facilities or services. In making decisions in the certificate of need review process, the ~~board~~ authority shall be guided by the state

health plan approved by the Governor.

§16-29B-12. Hearings; administrative procedures act applicable; hearings examiner; subpoenas.

(a) The ~~board~~ Health Care Authority may conduct such hearings as it deems necessary for the performance of its functions and shall hold hearings when required by the provisions of this chapter or upon a written demand therefor by a person aggrieved by any act or failure to act by the ~~board~~ Health Care Authority or by any legislative or procedural rule ~~regulation~~ or order of the ~~board~~ Health Care Authority. All hearings of the ~~board~~ Health Care Authority shall be announced in a timely manner and shall be open to the public except as may be necessary to conduct business of an executive nature. All hearings shall be conducted by the board of Directors who shall serve as the adjudicatory arm of the Health Care Authority. The Executive Director shall serve as the hearing examiner and shall preside over all hearings before the board.

(b) All pertinent provisions of article five, chapter twenty-nine-a of this code shall apply to and govern the hearing and administrative procedures in connection with and following the hearing except as specifically stated to the contrary in this article. The Executive Director shall assure that all hearings are to be conducted in a professional and respectful manner. The Executive Director, board members and all other participants involved in the hearing shall be courteous to those persons who appear before them and shall carefully examine all evidence and information presented. The General Counsel for the Authority shall represent the interest of the Authority at all hearings. No board member or the Executive Director may participate in a decision unless he or she has heard all of the information presented during the course of the hearing. If necessary, recesses in the hearing may be called. Decisions of the board shall be issued by the Executive Director as the hearing examiner for all hearings before the board pursuant to the provisions of this article.

(c) Any hearing may be conducted by ~~members of the board or by a hearing examiner appointed for such purpose~~ the Executive Director or his or her designee. ~~Any member of the board~~ The Executive Director may issue subpoenas and subpoenas duces tecum which shall be

issued and served pursuant to the time, fee and enforcement specifications in section one, article five, chapter twenty-nine-a of this code.

(d) Notwithstanding any other provision of state law, when a hospital alleges that a factual determination made by the board or the Executive Director is incorrect, the burden of proof shall be on the hospital to demonstrate that such determination is, in light of the total record, not supported by substantial evidence. The burden of proof remains with the hospital in all cases.

(e) After any hearing, after due deliberation, and in consideration of all the testimony, the evidence and the total record made, the board as the adjudicatory arm of the authority shall render a recommended decision in writing to the Executive Director. The recommended written decision shall be accompanied by findings of fact and conclusions of law as specified in section three, article five, chapter twenty-nine-a of this code, and forwarded to the Executive Director within thirty days of the hearing. The Executive Director shall approve the recommended decision as final within thirty days of receipt unless he or she finds a factual or legal error in the decision's findings or conclusions. If The Executive Director feels that there is insufficient information upon which to base the decision, he or she may remand the decision to the board for further consideration. The Executive Director may not consider any additional information in making the decision final that was not presented to the board during the course of the hearing. Once the Executive Director approves the decision as final the copy of the decision and accompanying findings and conclusions shall be served by certified mail, return receipt requested, upon the party demanding the hearing, and upon its attorney of record, if any.

(f) Any interested individual, group or organization shall be recognized as affected parties upon written request from the individual, group or organization. Affected parties shall have the right to bring relevant evidence before the ~~board~~ authority and testify thereon. Affected parties shall have equal access to records, testimony and evidence before the ~~board~~ authority, and shall have equal access to the expertise of the ~~board's~~ authority's staff. The Executive Director with advice from the board shall have authority to develop procedural rules ~~and regulations~~ to administer provisions of this section.

(g) The decision of the ~~board~~ Executive Director is final unless reversed, vacated or modified upon judicial review thereof, in accordance with the provisions of section thirteen of this article.

§16-29B-13. Review of final orders of board.

(a) A final decision of the ~~board~~ Executive Director and the record upon which it was made shall, upon request of any affected party, be reviewed by the agency of the state designated by the Governor to hear appeals under the provisions of article two-d of this chapter. To be effective, such request must be received within thirty days after the date upon which all parties received notice of the ~~board~~ Executive Director's final decision, and the hearing shall commence within thirty days of receipt of the request.

(b) For the purpose of administrative review of ~~board~~ Executive Director decisions, the review agency shall conduct its proceedings in conformance with the West Virginia rules of civil procedure for trial courts of record and the local rules for use in the civil courts of Kanawha County and shall review appeals in accordance with the provisions governing the judicial review of contested administrative cases in section four, article five, chapter twenty-nine-a of this code, notwithstanding the exceptions of section five, article five, chapter twenty-nine-a of this code.

(c) The decision of the review agency shall be made in writing within forty-five days after the conclusion of such hearing.

(d) The written findings of the review agency shall be sent to all affected parties, and shall be made available by the commission to others upon request.

(e) The decision of the review agency shall be considered the final decision of the ~~board~~ authority; however, the review agency may remand the matter to the ~~board~~ authority for further action or consideration.

(f) Upon the entry of a final decision by the review agency, any affected party may within thirty days after the date upon which all affected parties receive notice of the decision of the review agency, appeal said decision in the circuit court of Kanawha County. The decision of the review agency shall be reviewed by that circuit court in accordance with the provisions for the judicial

review of administrative decisions contained in section four, article five, chapter twenty-nine-a of this code.

§16-29B-14. Injunction; mandamus.

The ~~board~~ Executive Director may compel obedience to its lawful orders by injunction or mandamus or other proper proceedings in the name of the state in any circuit court having jurisdiction of the parties or of the subject matter, or the Supreme Court of Appeals direct, and such proceeding shall be determined in an expeditious manner.

§16-29B-15. Refusal to comply.

(a) Whenever a hospital fails or refuses to furnish to the Executive Director or the board any records or information requested under the provisions of this article or otherwise fails or refuses to comply with the requirements of this article or any reasonable legislative or procedural rule ~~and regulation~~ promulgated by the ~~board~~ authority under the provisions of this article, the board as the adjudicatory arm of the authority may make and enter an order of enforcement and serve a copy thereof on the hospital in question by certified mail, return receipt requested.

(b) The hospital shall be granted a hearing on the order of enforcement if, within twenty days after receipt of a copy thereof, it files with the ~~board~~ authority a written demand for hearing. A demand for hearing shall operate automatically to stay or suspend the execution of the order of enforcement, with the exception of orders relating to rate increases.

(c) Upon receipt of a written demand for a hearing, the ~~board~~ authority shall set a time and place therefor, not less than ten and no more than thirty days thereafter. Any scheduled hearing may be continued by the board upon motion for good cause shown by the hospital demanding the hearing.

§16-29B-17. Uniform system of financial reporting.

(a) The Executive Director with advice of the board shall develop and specify a uniform system of reporting utilization, accounting and financial reporting, including cost allocation methods by which hospitals shall record their revenues, income, expenses, capital outlays, assets, liabilities and units of service. The development and specification process aforementioned

shall be conducted in a manner determined by the Executive Director with advice of the board to be most efficient for that purpose notwithstanding the provisions of chapter twenty-nine-a of this code. Each hospital shall adopt this uniform system for the purpose of reporting utilization, costs and revenues to the ~~board~~ authority effective for the fiscal year beginning on or after twelve months from the effective date of this article.

(b) The ~~board~~ authority may provide for modification in the accounting and reporting system in order to correctly reflect differences in the scope or type of services and financial structures of the various categories, sizes and types of hospitals and in a manner consistent with the purposes of this article.

(c) The ~~board~~ authority may provide technical assistance to those hospitals which request it and which evidence sufficient need for assistance in the establishment of a data collection system to the extent that funds are available to the ~~board~~ authority for this purpose.

(d) The ~~board~~ authority shall, after consultation with health care providers, purchasers, classes of purchasers and third-party payors, adopt a mandatory form for reporting to the ~~board~~ authority, at its request, medical diagnosis, treatment and other services rendered to each purchaser by health care providers subject to the provisions of this article.

(e) Following a public hearing, the ~~board~~ authority shall establish a program to minimize the administrative burden on hospitals by eliminating unnecessary duplication of financial and operational reports; and to the extent possible, notwithstanding any other law, coordinate reviews, reports and inspections performed by federal, state, local and private agencies.

16-29B-18. Annual reporting.

(a) It shall be the duty of every health care provider which comes under the jurisdiction of this article and article five-f of this chapter to file with the ~~board~~ authority the reports required by such article five-f and the following financial statements or reports in a form and at intervals specified by the ~~board~~ authority, but at least annually:

(1) A balance sheet detailing the assets, liabilities and net worth of the hospital for its preceding fiscal year;

(2) A statement of income and expenses for the preceding fiscal year;

(3) A statement of services rendered and services available; and

(4) Such other reports as the ~~board~~ authority may prescribe.

Where more than one licensed hospital is operated by the reporting organization, the information required by this section shall be reported for each hospital separately.

(b) It shall be the duty of every related organization to file with the ~~board~~ authority, within thirty days from the effective date of this section, the following financial statements or reports for each of its three prior fiscal years:

(1) A balance sheet detailing the assets, liabilities and net worth of the related organization;

(2) A statement of income and expenses;

(3) A statement of cash flows; and

(4) Such other information as the ~~board~~ authority may prescribe.

After the initial filing of the financial information required by this subsection, every related organization shall thereafter file annual financial reports with the ~~board~~ authority in a form specified by the ~~board~~ authority.

(c) The annual financial statements filed pursuant to this section shall be prepared in accordance with the system of accounting and reporting adopted under section seventeen of this article. The ~~board~~ authority may require attestations from responsible officials of the hospitals or related organizations that such reports have to the best of their knowledge been prepared truthfully and in accordance with the prescribed system of accounting and reporting.

(d) All reports filed under any provisions of this article, except personal medical information personally identifiable to a purchaser and any tax return, shall be open to public inspection and shall be available for examination at the offices of the ~~board~~ authority during regular business hours.

(e) Whenever a further investigation is deemed necessary or desirable to verify the accuracy of any information set forth in any statement, schedule or report filed by a health care

provider or related organization under the provisions of this section, the ~~board~~ authority may require a full or partial audit of the records of the health care provider or related organization.

§16-29B-19a. Additional legislative directives; studies, findings and recommendations.

(a) The Legislature finds and declares that changing market forces require periodic changes in the regulatory structure for health care providers and hereby directs the ~~board~~ Executive Director or his or her designee to study the following:

(1) The certificate of need program, including the effect of any changes on managed care and access for uninsured and rural consumers; determining which services or capital expenditures should be exempt and why; ~~and~~ the status of similar programs in other states; is there a means to accommodate concerns of health care providers and hospitals situate in West Virginia which border states that do not have a certificate of need programs; and whether there exists a benefit to discontinuing the certificate of need program in its entirety. The results of the study should be presented to the Legislative Oversight Commission on Health and Human Resources Accountability by December 1, 2016;

~~(2) The hospital rate-setting methodology, including the need for hospital rate-setting and the development of alternatives to the cost-based reimbursement methodology;~~

~~(3)~~ (2) Managed care markets, including the need for regulatory programs in managed care markets; and

~~(4)~~ (3) Barriers or obstacles, if any, presented by the certificate of need program or standards in the state health plan to health care providers' need to reduce excess capacity, restructure services and integrate the delivery of services.

(b) The Executive Director may consult with the board and may form task forces to assist ~~it~~ in addressing these issues. ~~and it~~ The Executive Director or his or her designee shall prepare a report on ~~its~~ his or her findings and recommendations, which is to be filed with the Governor, the President of the Senate and the Speaker of the House of Delegates on or before ~~the first day of October, one thousand nine hundred ninety-eight~~ December 1, 2016, identifying each problem and recommendation with specificity and the effect of each recommendation on cost, access and

quality of care. The task forces, if formed, shall be composed of representatives of consumers, businesses, providers, payors and state agencies.

(c) The ~~board~~ Executive Director shall report quarterly to the Legislative Oversight Commission on Health and Human Resources Accountability regarding the appointment, direction and progress of the studies.

16-29B-22. Incentives.

The ~~board~~ authority shall be required to allow, as an incentive to the efficient management and operation of hospitals covered by this article, that if said hospitals are more efficient than anticipated, they shall retain a portion of the resulting savings and if less efficient shall bear the resulting deficits.

§16-29B-23. Utilization review and quality assurance; quality assurance advisory group.

(a) In order to avoid unnecessary or inappropriate utilization of health care services and to ensure high quality health care, the ~~board~~ authority shall establish a utilization review and quality assurance program. The ~~board~~ authority shall coordinate this program with utilization review and peer review programs presently established in state agencies, hospital services and health service corporations, hospitals or other organizations.

(b) With the assistance of the above-mentioned entities, and after public hearings, the ~~board~~ authority shall develop a plan for the review, on a sampling basis, of the necessity of admissions, length of stay and quality of care rendered at said hospitals.

(c) The ~~board~~ authority shall monitor identified problem areas and shall impose such sanctions and provide such incentives as necessary to ensure high quality and appropriate services and utilization in hospitals under the jurisdiction of this article.

(d) To assist the ~~board~~ authority in its efforts under this section, the ~~board~~ Executive Director shall create a quality assurance advisory group and appoint one of the board's members as chairman of the group. The group shall be composed of representatives of consumers, providers, payors and regulating agencies.

§16-29B-24. Powers with respect to insurance policies and health organizations.

(a) With respect to any policy of accident or health insurance, including, but not limited to, those insurance policies covered by articles fifteen, sixteen and sixteen-a, chapter thirty-three of this code, and with respect to any health service, care or maintenance organization, or similar health-related organizations, including, but not limited to, those covered by articles twenty-four, twenty-five and twenty-five-a, chapter thirty-three of this code, the ~~board~~ authority shall:

(1) Be considered for all purposes a directly affected party before the Insurance Commissioner for purposes of any application, hearing or appeal on insurance matters;

(2) Review requests for, and make comments on, proposed rate increases or coverage decreases submitted to the Insurance Commissioner with respect to the reasonableness of the request and impact on health care cost containment;

(3) Comment on the advisability, reasonableness and impact on health care cost containment of any other matter coming before the Insurance Commissioner or any other governmental agency or body.

(b) On or before the date of filing with the Insurance Commissioner of any rate, including any proposed increase or decrease thereof, and any coverage matter, including any proposed increase or decrease thereof, each company or organization, described in subsection (a) above, shall notify the ~~board~~ authority of such filing, by copy thereof or notice form, as the ~~board~~ authority directs.

(c) Each company or organization, described in subsection (a) above, shall establish, in a written report which shall be incorporated into each proposed rate application, that it has thoroughly investigated and considered:

(1) The economic and social impact of any proposed rate increase, or coverage decrease, on health care cost containment and upon health care purchasers, including classes of purchasers, such as the elderly and low and fixed income persons;

(2) State-of-the-art advances in insurance and health care management and rate design as alternatives to or in mitigation of any rate increase, or coverage decrease, which report shall describe the state-of-the-art advances considered and shall contain specific findings as to each

consideration, including the reasons for adoption or rejection of each:

(3) Implementation of cost control systems, including a combination of education, persuasion, financial incentives and disincentives to control costs;

(4) Initiatives to create alternative delivery systems; and

(5) Efforts to encourage health care providers to control costs, including the elimination of unnecessary or duplicative facilities and services, promotion of alternative forms of care, and other cost control mechanisms.

§16-29B-25. Public disclosure.

From time to time, the ~~board~~ authority shall engage in or carry out analyses and studies relating to health care costs, the financial status of any health care provider subject to the provisions of this article or any other appropriate related matters, and it shall be empowered to publish and disseminate any information which would be useful to members of the general public in making informed choices about health care providers.

§16-29B-26. Exemptions from state antitrust laws.

Actions of the ~~board~~ authority shall be exempt from antitrust action as provided in section five, article eighteen, chapter forty-seven of this code. Any actions of health care providers under the ~~board's~~ authority's jurisdiction, when made in compliance with orders, directives, rules or regulations issued or promulgated by the ~~board~~ authority, shall likewise be exempt. Health care providers shall be subject to the antitrust guidelines of the federal trade commission and the department of justice.

ARTICLE 29G. WEST VIRGINIA HEALTH INFORMATION NETWORK.

§16-29G-2. Creation of West Virginia Health Information Network board of directors; powers of the board of directors.

(a) The network is created under the Health Care Authority for administrative, personnel and technical support purposes. The network shall be managed and operated by a board of directors. The board of directors is an independent, self-sustaining board with the powers

specified in this article.

(b) The board is part-time. Each member shall devote the time necessary to carry out the duties and obligations of members on the board.

(c) Members appointed by the Governor may pursue and engage in another business or occupation or gainful employment that is not in conflict with his or her duties as a member of the board.

(d) The board shall meet at such times as the chair may decide. Eight members of the board are a quorum for the purposes of the transaction of business and for the performance of any duty.

(e) A majority vote of the members present is required for any final determination by the board. Voting by proxy is not allowed.

(f) The Governor may remove any board member for incompetence, misconduct, gross immorality, misfeasance, malfeasance or nonfeasance in office.

(g) The board shall consist of seventeen members, designated as follows:

(1) The Dean of the West Virginia University School of Medicine or his or her designee;

(2) The Dean of the Marshall University John C. Edwards School of Medicine or his or her designee;

(3) The President of the West Virginia School of Osteopathic Medicine or his or her designee;

(4) The Secretary of the Department of Health and Human Resources or his or her designee;

(5) The President of the West Virginia Board of Pharmacy or his or her designee;

(6) The Director of the Public Employees Insurance Agency or his or her designee;

(7) The Chief Technology Officer of the Office of Technology or his or her designee;

(8) The Chair of the Health Care Authority or his or her designee;

(9) The President of the West Virginia Hospital Association or his or her designee;

(10) The President of the West Virginia State Medical Association or his or her designee;

(11) The Chief Executive Officer of the West Virginia Health Care Association or his or her designee;

(12) The Executive Director of the West Virginia Primary Care Association or his or her designee; and

(13) Five public members that serve at the will and pleasure of the Governor and are appointed by the Governor with advice and consent of the Senate as follows:

(i) One member with legal expertise in matters concerning the privacy and security of health care information;

(ii) Two physicians actively engaged in the practice of medicine in the state;

(iii) One member engaged in the business of health insurance who is employed by a company that has its headquarters in West Virginia; and

(iv) The chief executive officer of a West Virginia corporation working with West Virginia health care providers, insurers, businesses and government to facilitate the use of information technology to improve the quality, efficiency and safety of health care for West Virginians.

(h) The Governor shall appoint one of the board members to serve as chair of the board at the Governor's will and pleasure. The board shall annually select one of its members to serve as vice chair. The ~~Chair~~ Executive Director of the Health Care Authority shall serve as the secretary-treasurer of the board.

(i) The public members of the board shall serve a term of four years and may serve two consecutive terms. At the end of a term, a member of the board shall continue to serve until a successor is appointed. Those members designated in subdivisions (1) through (12), inclusive, subsection (g) of this section shall serve on the board only while holding the position that entitle them to membership on the board.

(j) The board may propose the adoption or amendment of rules to the Health Care Authority to carry out the objectives of this article.

(k) The board may appoint committees or subcommittees to investigate and make recommendations to the full board. Members of such committees or subcommittees need not be

members of the board.

(l) Each member of the board and the board's committees and subcommittees is entitled to be reimbursed for actual and necessary expenses incurred for each day or portion thereof engaged in the discharge of official duties in a manner consistent with guidelines of the Travel Management Office of the Department of Administration.

§16-29G-4. Creation of the West Virginia Health Information Network account; authorization of Health Care Authority to expend funds to support the network.

(a) All moneys collected shall be deposited in a special revenue account in the State Treasury known as the West Virginia Health Information Network Account. Expenditures from the fund shall be for the purposes set forth in this article and are not authorized from collections but are to be made only in accordance with appropriation by the Legislature and in accordance with the provisions of article three, chapter twelve of this code and upon fulfillment of the provisions of article two, chapter eleven-b of this code: *Provided*, That for the fiscal year ending June 30, 2007, expenditures are authorized from collections rather than pursuant to appropriations by the Legislature.

(b) Consistent with section eight, article twenty-nine-b of this chapter, the Health Care Authority's provision of administrative, personnel, technical and other forms of support to the network is necessary to support the activities of the Health Care Authority ~~board~~ and constitutes a legitimate, lawful purpose of the Health Care Authority. ~~board~~ Therefore, the Health Care Authority is hereby authorized to expend funds from its Health Care Cost Review Fund, established under section eight, article twenty-nine-b of this chapter, to support the network's administrative, personnel and technical needs and any other network activities the Health Care Authority deems necessary.

§16-29G-5. Immunity from suit; limitation of liability.

The network is not a health care provider and is not subject to claims under article seven-b, chapter fifty-five of this code. No person who participates or subscribes to the services or information provided by the network is liable in any action for damages or costs of any nature, in

law or equity, which result solely from that person's use or failure to use network information or data that was imputed or retrieved in accordance with the Health Insurance Portability and Accountability Act of 1996 and any amendments and regulations under the act, state confidentiality laws and the rules of the network as approved by the Executive Director of the Health Care Authority. In addition, no person is subject to antitrust or unfair competition liability based on membership or participation in the network, which provides an essential governmental function for the public health and safety and enjoys state action immunity.

§16-29G-6. Property rights.

(a) All persons providing information and data to the network shall retain a property right in that information or data, but grant to the other participants or subscribers a nonexclusive license to retrieve and use that information or data in accordance with the Health Insurance Portability and Accountability Act of 1996 and any amendments and regulations under the act, state confidentiality laws and the legislative rules proposed by the Health Care Authority.

(b) All processes or software developed, designed or purchased by the network shall remain its property subject to use by participants or subscribers in accordance with the rules ~~or regulations~~ proposed by the Health Care Authority.

ARTICLE 29I. WEST VIRGINIA HEALTH CARE AUTHORITY REVOLVING LOAN AND GRANT FUND.

§16-29I-4. Revolving fund created.

(a) (1) The ~~board~~ authority shall create and establish a special revolving fund of moneys made available to the fund by appropriation, grant, contribution, loan, or statutory dedication to be known as the West Virginia Health Care Authority Revolving Loan Fund. The fund shall be governed, administered and accounted for by the ~~board~~ Executive Director or his or her designee.

(2) Any money collected pursuant to this section, including the repayment of loans made by the ~~board~~ authority, shall be paid into the fund by any state agent or entity charged with the collection of the money, credited to the fund, and used only for the purposes set forth in this article.

(b) The ~~board~~ authority may pledge revenues to the fund and from time to time establish one or more restricted accounts within the fund for the purpose of providing funds to guarantee loans made pursuant to this article. No loan guarantee shall be made pursuant to this article unless recourse under the loan guarantee is limited solely to amounts in the restricted account or accounts. No person shall have any recourse to any restricted accounts established pursuant to this subsection other than those persons to whom the loan guarantee or loan guarantees have been made.

(c) Each loan or loan guarantee made or provided by the ~~board~~ authority from the fund shall be evidenced by a loan document, a loan guarantee document or any other writing or document or documents as the ~~board~~ authority may consider appropriate, between the Health Care Authority ~~Board~~ and the hospital or hospitals to which the loan, or loan guarantee, was made available or provided. The agreements shall include, without limitation and to the extent applicable, the following provisions:

(1) The estimated total costs of the hospital restructuring plan, the amount of the loan, or loan guarantee and the terms of repayment and the security for the loan if any;

(2) The specific purposes for which the loan proceeds shall be expended and the conditions and procedures for dispersing a loan proceeds; and

(3) The duties, conditions and obligations imposed by the ~~board~~ authority upon the hospital or hospitals regarding the hospital restructuring plan.

(d) Moneys in the fund shall be approved for expenditure by the Health Care Authority ~~Board~~ only as the moneys are available in the fund. Approval of expenditures by the ~~board~~ authority may occur without appropriation by the Legislature prior to July 1, 2008. After July 1, 2008, expenditures from the fund shall be made by the ~~board~~ authority only pursuant to available amounts appropriated by the Legislature.

NOTE: The purpose of this bill is to create the position of Executive Director of the Health Care Authority to act as the administrative head of the agency; to change the number and make-up of the board of directors and to clarify their powers and duties; to require that the

members of the board of the West Virginia Health Care Authority be employed on a part time basis and that the compensation for board members be set in statute; to eliminate rate review from the Health Care Authority powers and duties.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.