WEST VIRGINIA LEGISLATURE
FIRST REGULAR SESSION, 1991

ENROLLED
Com. Sel. for
HOUSE BILL No. 2191

(By Mr. Speaker, Mr. Chambers, and
Del. P. Berk
By Request of the Executive)

Passed ........... March 6 .................... 1991

In Effect From Passage
ENROLLED
COMMITTEE SUBSTITUTE
FOR
H. B. 2194
(By Mr. Speaker, Mr. Chambers, and Delegate R. Burk)
[By Request of the Executive]

[Passed March 6, 1991; in effect from passage.]

AN ACT to amend and reenact sections two, four, five and eleven, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact sections one, two, three, four, five and six, article five-f; and sections three, five, seven, eight, eighteen, twenty, twenty-one and twenty-eight, article twenty-nine-b of said chapter; and to further amend said article twenty-nine-b by adding thereunto two new sections, designated sections six and nineteen-a, all relating to health care cost containment; providing definitions; reducing expense and expenditure thresholds governing when certificate of need review is required; eliminating certain exemptions from certificate of need review; extending moratorium on intermediate care and skilled nursing beds; providing for the conversion of certain beds; defining transfer of certificate of need; expanding scope of covered facility reporting and financial disclosure requirements to include related organizations; requiring covered facilities and related organizations to furnish copies of tax returns; requiring confidentiality of tax returns; requiring report to governor and legislature; continuing health care cost review authority until the first day
of July, one thousand nine hundred ninety-seven; deleting term limitation on board membership; increasing salaries of board members; creating health care cost review council to serve as advisory body to the board; exempting staff of health care cost review authority from civil service salary schedules; permitting promulgation of certain emergency rules; mandating cost-based review system; exempting regulations implementing cost-based review system from legislative rule-making; requiring filing of certain contracts; requiring contracts granting discounts to purchasers or third-party payors be reviewed and approved by the health care cost review authority; and changing standard for automatic rate increases.

Be it enacted by the Legislature of West Virginia:

That sections two, four, five and eleven, article two-d, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted; that sections one, two, three, four, five and six, article five-f; and sections three, five, seven, eight, eighteen, twenty, twenty-one and twenty-eight, article twenty-nine-b of said chapter be amended and reenacted; and that said article twenty-nine-b be further amended by adding thereto two new sections, designated sections six and nineteen-a, all to read as follows:

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-2. Definitions.

1 As used in this article, unless otherwise indicated by
2 the context:
3 (a) "Affected person" means:
4 (1) The applicant;
5 (2) An agency or organization representing
6 consumers;
7 (3) Any individual residing within the geographic
8 area served or to be served by the applicant;
9 (4) Any individual who regularly uses the health care
10 facilities within that geographic area;
(5) The health care facilities 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 which, prior to receipt by the state agency of the proposal being reviewed, have formally indicated an intention to provide similar services in the future;

(7) Third-party payers who reimburse health care facilities similar to those proposed for services;

(8) Any agency which establishes rates for health care facilities similar to those proposed; or

(9) Organizations representing health care providers.

(b) "Ambulatory health care facility" means a facility which is free-standing and not physically attached to a health care facility and which provides health care to noninstitutionalized and nonhomebound persons on an outpatient basis. This definition does not include 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 such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: Provided, however, That such exemption from review of private office practice shall 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 facility which is free-standing and not physically attached to a health care facility and which provides surgical treatment to patients not requiring hospitalization. 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 such exempt-
tion from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: Provided, however, That such exemption from review of private office practice shall 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.

(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 such 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 for which a license is issued to a health care facility, or, if a facility is unlicensed, the number of adult and pediatric beds permanently staffed and maintained for immediate use by inpatients in patient rooms or wards.

(f) "Capital expenditure" means an expenditure:

(1) Made by or on behalf of a health care facility; and

(2) (A) Which (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) which (i) exceeds the expenditure minimum, or (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. For purposes of subparagraph (i), paragraph (B), subdivision (2) of this definition, 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 with respect to which an expenditure described in paragraph (B), subdivision (2) of this definition is made shall be included in determining if such expenditure exceeds the expenditure minimum. Donations of equipment or facilities to a health care facility which if acquired directly by such facility would be subject to review shall be considered capital expenditures, and a transfer of equipment or facilities for less than fair market value shall be considered a capital expenditure for purposes of such subdivisions if a transfer of the equipment or facilities at fair market value would be subject to review. A series of expenditures, each less than the expenditure minimum, which when taken together are in excess of the expenditure minimum, may be determined by the state agency to be a single capital expenditure subject to review. In making its 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.

(g) “Expenditure minimum” means seven hundred fifty thousand dollars per fiscal year.

(h) “Health,” used as a term, includes physical and mental health.

(i) “Health care facility” is defined as including 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, rehabilitation facilities and health maintenance organizations; community mental health and mental retardation facilities, 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. For purposes of this definition, “community mental health and mental retardation facility” means a private facility which provides such comprehensive services and continuity of care as emergency, outpatient, partial hospitalization, inpatient and consultation and education for individuals with mental illness, mental retardation or drug or alcohol addiction.

(j) “Health care provider” means a person, partnership, corporation, facility 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 care, treatment or confinement.

(k) “Health maintenance organization” means a public or private organization, organized under the laws of this state, which:

(1) Is a qualified health maintenance organization under Section 1310(d) of the Public Health Service Act, as amended, Title 42 United States Code Section 300e-9(d); 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; and

(B) Is compensated except for copayments for the provision of the basic health care services listed in subdivision (2), paragraph (A), subdivision (k) of this definition 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 primarily (i) directly through physicians who are either employees or
partners of such organization, or (ii) through arrange-
ments with individual physicians or one or more groups
of physicians organized on a group practice or individ-
ual practice basis.

(l) "Health services" means clinically related preven-
tive, diagnostic, treatment or rehabilitative services,
including alcohol, drug abuse and mental health
services.

(m) "Home health agency" is an organization primar-
ily engaged in providing directly or through contract
arrangements, professional nursing services, home
health aide services, and other therapeutic and related
services, including, but not limited to, physical, speech
and occupational therapy and nutritional and medical
social services to persons in their place of residence on
a part-time or intermittent basis.

(n) "Hospital" means an institution 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, or rehabilitation
services for the rehabilitation of injured, disabled or sick
persons. This term also includes psychiatric and
tuberculosis hospitals.

(o) "Intermediate care facility" means an institution
which provides, on a regular basis, health-related care
and services to individuals who do not require the
degree of care and treatment which a hospital or skilled
nursing facility is designed to provide, but who, because
of their mental or physical condition require health-
related care and services above the level of room and
board.

(p) "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. Each long-range plan
shall consist of the information required by the state
agency in regulations adopted pursuant to section eight
of this article.
(q) "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 which costs in excess of three hundred thousand dollars, except that such 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 of Section 1861(s) of such act, Title 42 United States Code Sections 1395x (10) and (11). In determining whether medical equipment costs more than three hundred thousand dollars, 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.

(r) "Medically underserved population" means the population of an urban or rural area designated by the state agency as an area with a shortage of personal health services or a population having a shortage of such services, after taking into account unusual local conditions which are a barrier to accessibility or availability of such services. Such designation shall be in regulations 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 United States Code Section 254(b)(3).

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

(t) "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 for the provision of, specified health services.
(u) "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.

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

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

(x) "Psychiatric hospital" means an institution which 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.

(y) "Rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

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

(aa) "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(bb) "State agency" means the health care cost review authority created, established, and continued pursuant to article twenty-nine-b of this chapter.

(cc) "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 health care planning council or its successor agency.

(dd) "Health care planning council" means the body
established by section five-a of this article to participate in the preparation and amendment of the state health plan and to advise the state agency.

(ee) "Substantial change to the bed capacity" of a health care facility means any change, with which a capital expenditure is associated, 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 shall be excluded from this definition.

(ff) "Substantial change to the health services" of a health care facility means the addition of a health service which is offered by or on behalf of the health care facility and 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 the termination of a health service which was offered by or on behalf of the facility, but does not include the providing of hospice care, ambulance service, wellness centers or programs, adult day care, or respite care by acute care facilities.

(gg) "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-4. Exemptions from certificate of need program.

(a) Except as provided in subdivision (h), section three of this article, nothing in this article or the rules and regulations adopted pursuant to the provisions of this article may be construed to authorize the licensure, supervision, regulation or control in any manner of the following:

(1) 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 such exemption from review of private office practice shall not be construed to include such practices where major medical equipment otherwise subject to review under the provisions of this article is acquired, offered or developed: Provided, however, That such exemption from review of private office practice shall not be construed to include the acquisition, offering or development of one or more health services, including ambulatory surgical facilities or centers, lithotripsy, magnetic resonance imaging and radiation therapy by one or more health professionals. The state agency shall adopt rules pursuant to section eight of this article which specify the health services acquired, offered or developed by health professionals which are subject to certificate of need review;

(2) Dispensaries and first-aid stations located within business or industrial establishments maintained solely for the use of employees: Provided, That such facility does not contain inpatient or resident beds for patients or employees who generally remain in the facility for more than twenty-four hours;

(3) Establishments, such as motels, hotels and boardinghouses, which provide medical, nursing personnel and health related services; and

(4) The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

(b) (1) A certificate of need is not required for the offering of an inpatient institutional health service or the acquisition of major medical equipment for the provision of an inpatient institutional health service or the obligation of a capital expenditure for the provisions of an inpatient institutional health service, if with respect to such offering, acquisition or obligation, the state agency has, upon application under subdivision (2), subsection (b) of this section, granted an exemption to:

(A) A health maintenance organization or a combina-
tion of health maintenance organizations if (i) the organization or combination of organizations has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (ii) the facility in which the service will be provided is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination;

(B) A health care facility if (i) the facility primarily provides or will provide inpatient health services, (ii) the facility is or will be controlled, directly or indirectly, by a health maintenance organization or a combination of health maintenance organizations which has, in the service area of the organization or service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals, (iii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iv) at least seventy-five percent of the patients who can reasonably be expected to receive the institutional health service will be individuals enrolled with such organization or organizations in the combination; or

(C) A health care facility, or portion thereof, if (i) the facility is or will be leased by a health maintenance organization or combination of health maintenance organizations which has, in the service area of the organization or the service areas of the organizations in the combination, an enrollment of at least fifty thousand individuals and on the date the application is submitted under subdivision (2), subsection (b) of this section, at least fifteen years remain in the term of the lease, (ii) the facility is or will be geographically located so that the service will be reasonably accessible to such enrolled individuals, and (iii) at least seventy-five percent of the patients who can reasonably be expected to receive the new institutional health service will be individuals enrolled with such organization.
(2) (A) A health maintenance organization, combination of health maintenance organizations, or other health care facility is not exempt under subdivision (1), subsection (b) of this section from obtaining a certificate of need unless:

(i) It has submitted, at such time and in such form and manner as the state agency shall prescribe, an application for such exemption to the state agency;

(ii) The application contains such information respecting the organization, combination or facility and the proposed offering, acquisition or obligation as the state agency may require to determine if the organization or combination meets the requirements of subdivision (1), subsection (b) of this section or the facility meets or will meet such requirements; and

(iii) The state agency approves such application.

(B) The state agency shall approve an application submitted under paragraph (A), subdivision (2), subsection (b) of this section, if it determines that the applicable requirements of subdivision (1), subsection (b) of this section, are met or will be met on the date the proposed activity for which an exemption was requested will be undertaken.

(3) A health care facility, or any part thereof, or medical equipment with respect to which an exemption was granted under subdivision (1), subsection (b) of this section, may not be sold or leased and a controlling interest in such facility or equipment or in a lease of such facility or equipment may not be acquired and a health care facility described in paragraph (C), subdivision (1), subsection (b) of this section, which was granted an exemption under subdivision (1), subsection (b) of this section, may not be used by any person other than the lessee described in paragraph (C), subdivision (1), subsection (b) of this section, unless:

(A) The state agency issues a certificate of need approving the sale, lease, acquisition or use; or

(B) The state agency determines, upon application, that the entity to which the facility or equipment is
proposed to be sold or leased, which intends to acquire
the controlling interest in or to use the facility is:

(i) A health maintenance organization or a combina-
tion of health maintenance organizations which meets
the enrollment requirements of subparagraph (i),
paragraph (A), subdivision (1), subsection (b) of this
section, and with respect to such facility or equipment,
the entity meets the accessibility and patient enrollment
requirements of subparagraph (ii) and (iii), paragraph
(A), subdivision (1), subsection (b) of this section; or

(ii) A health care facility which meets the inpatient,
enrollment and accessibility requirements of subpara-
graph (i), (ii) and (iii), paragraph (B), subdivision (1),
subsection (b) of this section and with respect to its
patients meets the enrollment requirements of subpara-
graph (iv), paragraph (B), subdivision (1), subsection (b)
of this section.

(4) In the case of a health maintenance organization
or an ambulatory care facility or health care facility
which ambulatory or health care facility is controlled,
directly or indirectly, by a health maintenance organ-
ization or a combination of health maintenance organ-
izations, the certificate of need requirements apply only
to the offering of inpatient institutional health services,
the acquisition of major medical equipment, and the
obligation of capital expenditures for the offering of
inpatient institutional health services and then only to
the extent that such offering, acquisition or obligation
is not exempt under subdivision (1), subsection (b) of this
section.

(5) The state agency shall establish the period within
which approval or disapproval by the state agency of
applications for exemptions under subdivision (1),
subsection (b) of this section, shall be made.

(c) (1) A health care facility is not required to obtain
a certificate of need for the acquisition of major medical
equipment to be used solely for research, the addition
of health services to be offered solely for research, or the
obligation of a capital expenditure to be made solely for
research if the health care facility provides the notice
required in subdivision (2), subsection (c) of this section, and the state agency does not find, within sixty days after it receives such notice, that the acquisition, offering or obligation will, or will have the effect to:

(A) Affect the charges of the facility for the provision of medical or other patient care services other than the services which are included in the research;

(B) Result in a substantial change to the bed capacity of the facility; or

(C) Result in a substantial change to the health services of the facility.

(2) Before a health care facility acquires major medical equipment to be used solely for research, offers a health service solely for research, or obligates a capital expenditure solely for research, such health care facility shall notify in writing the state agency of such facility's intent and the use to be made of such medical equipment, health service or capital expenditure.

(3) If major medical equipment is acquired, a health service is offered, or a capital expenditure is obligated and a certificate of need is not required for such acquisition, offering or obligation as provided in subdivision (1), subsection (c) of this section, such equipment or service or equipment or facilities acquired through the obligation of such capital expenditure may not be used in such a manner as to have the effect or to make a change described in paragraphs (A), (B) and (C), subdivision (1), subsection (c) of this section unless the state agency issues a certificate of need approving such use.

(4) For purposes of this subsection, the term "solely for research" includes patient care provided on an occasional and irregular basis and not as part of a research program.

(d) (1) The state agency may adopt regulations pursuant to section eight of this article to specify the circumstances under which a certificate of need may not be required for the obligation of a capital expenditure to acquire, either by purchase or under lease or
provided, that a certificate of need shall be required for the obligation of a capital expenditure to acquire, either by purchase or under lease or comparable arrangement, an existing health care facility if:

(A) The notice required by subdivision (2), subsection (d) of this section is not filed in accordance with that subdivision with respect to such acquisition; or (B) the state agency finds, within thirty days after the date it receives a notice in accordance with subdivision (2), subsection (d) of this section, with respect to such acquisition, that the services or bed capacity of the facility will be changed by reason of said acquisition.

(2) Before any person enters into a contractual arrangement to acquire an existing health care facility, such person shall notify the state agency of his or her intent to acquire the facility and of the services to be offered in the facility and its bed capacity. Such notice shall be made in writing and shall be made at least thirty days before contractual arrangements are entered into to acquire the facility with respect to which the notice is given. The notice shall contain all information the state agency requires in accordance with subsections (e) and (s), section seven of this article.

(e) The state agency shall adopt regulations, pursuant to section eight of this article, wherein criteria are established to exempt from review the addition of certain health services, not associated with a capital expenditure, that are projected to entail annual operating costs of less than the expenditure minimum for annual operating costs. For purposes of this subsection, "expenditure minimum for annual operating costs" means three hundred thousand dollars for the first twelve months following the effective date of this section and for each twelve-month period thereafter, the state agency may, by regulations adopted pursuant to section eight of this article, adjust the expenditure minimum for annual operating costs to reflect the impact of inflation.

(f) The state agency shall adopt rules within ninety
days of the effective date of the amendment of this
pursuant to section eight of this article to specify the
circumstances under which and the procedures by
which a certificate of need may not be required for
shared services between two or more acute care
facilities providing services made available through
existing technology that can reasonably be mobile. The
state agency shall specify the types of items in the
regulations and under what circumstances mobile MRI
and mobile lithotripsy may be so exempted from review.
In no case, however, will mobile cardiac catheterization
be exempted from certificate of need review. In
addition, if the shared services mobile unit proves less
cost effective than a fixed unit, the acute care facility
will not be exempted from certificate of need review.

On a yearly basis, the state agency shall review
existing technologies to determine if other shared
services should be included under this exemption.

§16-2D-5. Powers and duties of state health planning and
development agency.

(a) The state agency is hereby empowered to admin-
ister the certificate of need program as provided by this
article.

(b) The state agency shall cooperate with the health
care planning council or its successor agency in
developing rules and regulations for the certificate of
need program to the extent appropriate for the achieve-
ment of efficiency in their reviews and consistency in
criteria for such reviews.

(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 appro-
priately 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 assur-
(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 such 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. The state agency shall implement this subsection by filing procedural rules pursuant to chapter twenty-nine-a of this code. 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) No hospital, nursing home or other health care facility shall 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 and subsection (i), section five of this article may convert acute care beds to skilled nursing beds in accordance with the provisions of these sections, upon approval by the state agency. Furthermore, no certificate of need shall 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
the effective date of this section must incur an
obligation for a capital expenditure within twelve
months of the date of issuance of the certificate of need.
No extensions shall be granted beyond the twelve month
period.

(h) No additional intermediate care facility for the
mentally retarded (ICF/MR) beds shall 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 the third day of August,
one thousand nine hundred eighty-nine, civil action
number MISC-81-585 issued in the case of E. H. v.
Matin, 168 West Virginia 248, 284 S.E.2d 232 (1981) and
does not apply to existing ICF/MR beds to be replaced,
sold, leased, transferred, or operated under contract or
other means.

(i) Notwithstanding the provisions of subsection (g),
section five of this article and, further notwithstanding
the provisions of subsection (d), section three of this
article, an existing acute care hospital may apply to the
health care cost review 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 is prohibited from
billing for any medicaid reimbursement for any beds so
converted. In converting beds, the hospital must convert
a minimum of one acute care bed into one medicare
certified only skilled nursing bed. The health care cost
review authority may require a hospital to convert up
to and including three acute care beds for each medicare
certified only skilled nursing bed. The health care cost
review 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 (d),
section three of this article for which purposes such 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 (ee), 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 must demonstrate a need for the
project.
(4) The hospital must 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 must 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 shall negatively affect the
rights of inspection and certification which are other-
wise required by federal law or regulations or by this
code of duly adopted regulations of an authorized state
entity.

(j) Notwithstanding the provisions of subsection (g),
section five, of this article, a retirement life care center
with no skilled nursing beds may apply to the health
care cost review 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 shall
not be applicable to projects submitted under this
subsection. The health care cost review authority shall
adopt rules to implement this subsection which shall
include:

(1) A requirement that the one hundred eighty beds
are to be distributed on a statewide basis;

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

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

(4) The retirement center must demonstrate a need for the project;

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

(6) The retirement center must demonstrate both short and long-term financial feasibility.

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

(k) The provisions of this article are severable and if any provision, section or part thereof shall be held invalid, unconstitutional or inapplicable to any person or circumstance, such invalidity, unconstitutionality or inapplicability shall not affect or impair any other remaining provisions contained herein.

§16-2D-11. Nontransference, time period compliance and withdrawal of certificate of need.

(A) A certificate of need is nontransferable and shall be valid for a maximum of one year from the date of issuance. A transfer includes the sale, lease, transfer of stock or partnership shares, or other comparable arrangement which has the effect of transferring the control of the owner of the certificate of need. Upon the expiration of the certificate or during the certification period the person proposing the new institutional health service shall provide the state agency such information on the development of the project as the state agency may request. The state agency shall periodically monitor
capital expenditures obligated under certificates, determine whether sufficient progress is being made in meeting the timetable specified in the approved application for the certificate and whether there has been compliance with the application and any conditions of certification. The state agency shall take into account recommendations made by the health systems agency in making its determination. The certificate of need may be extended by the state agency for additional periods of time as are reasonably necessary to expeditiously complete the project. A certificate of need may no longer be in effect, and may no longer be required, after written notice of substantial compliance with the approved application and any conditions of certification is issued to the applicant, after the activity is undertaken for which the certificate of need was issued, and after the state agency is provided written notice of such undertaking. The person proposing a new institutional health service may not be issued a license therefor until the state agency has issued a written notice of substantial compliance with the approved application and any conditions of certification, nor may a new institutional health service be used until such person has received such notice. A new institutional health service may not be found to be in substantial compliance with the approved application and any conditions of certification if there is a substantial change, as defined in regulations adopted pursuant to subsection (i), section three of this article, in the approved new institutional health service for which change a certificate of need has not been issued.

(B)(1) The certificate of need may be withdrawn by the state agency for:

(a) Insufficient progress in meeting the timetable specified in the approved application for the certificate and for not making a good faith effort to meet it in developing the project; or

(b) Noncompliance with any conditions of certification; or

(c) A substantial change, as defined in regulations
adopted pursuant to subsection (i), section three of this article, in an approved new institutional health service for which change a certificate of need has not been issued; or

(d) Material misrepresentation by an applicant upon which the state agency relied in making its decision; or

(e) Other reasons that may be established by the state agency in regulations adopted pursuant to section eight of this article.

(2) Any decision of the state agency to withdraw a certificate of need shall be based solely on:

(A) The provisions of this article and on regulations adopted in accordance with section eight of this article; and

(B) The record established in administrative proceedings held with respect to the state agency's proposal to withdraw the certificate.

(3) In the case of a proposed withdrawal of a certificate of need:

(A) After commencement of a hearing on the state agency's proposal to withdraw a certificate of need and before a decision is made on withdrawal, there may be no ex parte contacts between (i) the holder of the certificate of need, any person acting on behalf of the holder, or any person in favor of the withdrawal and (ii) any person in the state agency who exercises responsibility respecting withdrawal of the certificate;

(B) The state agency shall follow the notification of review provisions of subsections (g) and (h), the public hearing provisions of subsection (n), the notification of the status of review and findings provisions of subsection (g), the annual report provisions of subsection (r), and the reconsideration provisions of subsection (t), all of section seven of this article, and the conditional decision provisions of subsection (d), the notification of decision and findings provisions of subsection (h), and the statement to the applicable health systems agency provisions of subsection (k), all of section nine of this
(C) Appeals of withdrawals of certificates of need shall be made pursuant to section ten of this article.

(4) A new institutional health service may not be acquired, offered, or developed within this state if a certificate of need authorizing that new institutional health service has been withdrawn by the state agency and the acquisition, offering, or development of the new institutional health service is subject to review under this article.

ARTICLE 5F. HEALTH CARE FACILITY FINANCIAL DISCLOSURE.

§16-5F-1. Legislative findings; purpose; intent of article.

(1) The West Virginia Legislature finds that the rising cost of health care and services provided by health care facilities are matters of vital concern to the people of this state and have a direct relationship to the ability of the people to obtain necessary health care.

(2) The citizens of this state have an inherent right to receive and have available to them health care programs and services which are capable of meeting individual needs.

(3) Such services should be available to all citizens in all regions of this state.

(4) The furnishing of health care services is an essential public service.

(5) The public has a right to know the financial position of facilities and related organizations.

It is the purpose of this article to provide that the facilities and organizations covered herein shall make a public disclosure of their financial position and to bring about a review as to the reasonableness of the costs of health care services.

§16-5F-2. Definitions.

As used in this article:

(1) "Annual report" means an annual financial report
(2) "Board" means the West Virginia Health Care Cost Review 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; rehabilitation facility; health maintenance organization; or community mental health or mental retardation 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.

(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 subsection family members shall mean brothers and sisters whether by the whole or half blood, spouse, ancestors and lineal descendents.

(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 elsewhere in this article, the board shall have the powers as indicated by this section and it shall be its duty to:

(1) Promulgate 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 organization.

(b) The board 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 shall, not later than December thirty-first 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 the first day of July, one thousand nine hundred ninety-two, 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 for good cause shown, shall be required to file with the board 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 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 the following statements, schedules or reports in such form and at such intervals as may be specified by the board, 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 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 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 fifty-five thousand dollars 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 fifty-five thousand dollars during the period reported;

(6) Such other reports of the costs incurred in rendering services as the board may prescribe. The board 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 pursuant to the provisions of subdivision four, 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 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 may establish fees reasonably calculated to reimburse the board 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 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 shall have the authority to require the production of any records necessary to verify such information.

(f) From time to time, the board 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, 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 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 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 one
thousand dollars for each day thereafter that such
failure continues, such penalty to be recovered by the
board 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. WEST VIRGINIA HEALTH CARE COST REVIEW
AUTHORITY.

§16-29B-3. Definitions.

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

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

(b) “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 bene-
cficiaries, 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;

(c) “Board” means the three member board of
directors of the West Virginia health care cost review
authority, and autonomous division within the state
department of health;

(d) “Health care provider” means a person, partner-
ship, corporation, facility 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 care, treatment or
confinement;

(e) "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) "Person" means an individual, trust, estate, partnership, committee, corporation, association or other organization such as a joint stock company, estate or political subdivision or instrumentality thereof;

(g) "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 hospital, but does not include third-party payors;

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

(i) "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;

(j) "Third-party payor" means any natural person, person, corporation or government entity responsible for payment for patient care services rendered by hospitals;

and

(k) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for-profit, related to a hospital through common membership, governing bodies, trustees, officers, stock owner-
ship, 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 descendents.

§16-29B-5. West Virginia health care cost review authority continued; composition of the board; qualifications; terms; oath; compensation and expenses of members; vacancies; appointment of chairman, and meetings of the board.

1 The "West Virginia Health Care Cost Review Authority," heretofore created as an autonomous division of the department of health, hereinafter referred to as the board, is hereby continued as an autonomous division of the department of health and human resources.

(a) The board shall consist of three members, appointed by the governor, with the advice and consent of the senate. The board members shall be citizens and residents of this state. No more than two of said 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 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 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. 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. The governor shall appoint three board members, one for a term of two years, one for a term of four years and one for a term of six years, with all the terms beginning on the effective date of this article. All future appointments shall be for terms of six years, except that an appointment to fill a vacancy shall be for the unexpired term only.

(c) No person while in the employ of, or holding any official relation to, any hospital subject to the provisions of this article, or who has any pecuniary interest therein, may serve as a member of the board or as an employee thereof. Nor may any such board member be a candidate for or hold public office or be a member of any political committee while acting as such board member; nor may any board member or employee of said board receive anything of value, either directly or indirectly from any hospital subject to the provisions of this article. Should any of the board members become a candidate for any public office or for membership on any political committee, the governor shall remove said board member from the board and shall appoint a new board member to fill the vacancy created. No board member may accept employment with any hospital subject to the jurisdiction of the board within two years after said board member ceases to be a board member.

(d) The concurrent judgment of two of the board members when in session as the board shall be deemed 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.

(e) In order to adequately compensate the chairman of the board and other members of the board for additional duties newly imposed by law and not heretofore required by law the annual salary of the chairman of the board shall be fifty-five thousand dollars and the annual salary of the other board members shall be thirty-six thousand five hundred dollars: Provided, That effective the first day of July, one thousand nine hundred ninety-one, the annual salary of other board members shall be fifty-one thousand two hundred dollars.
§16-29B-6. Advisory council.

There is created the West Virginia health care cost review council, hereinafter referred to as the council:

(a) The council is composed of thirteen members. Five of the members shall be defined as government members, those members being the secretary of the department of health and human resources, the workers' compensation commissioner or the successor to his or her duties and responsibilities, the director of the public employees insurance agency, the commissioner of insurance, and the director of the division of vocational rehabilitation, or their respective designated representatives. Eight members shall be defined as nongovernment members who shall be appointed by the governor, with the advice and consent of the senate, and shall be selected as follows: one representative of the health insurance industry, one administrator of a small hospital, one physician, and four members who are consumers of health services. When selecting the members who are consumers of health services, in addition to other factors, consideration shall be given to constituencies of organized labor, major purchasers of health insurance, and senior citizens.

(b) No more than five of the nongovernment members of the council may belong to the same political party, and at least two but no more than four may reside in the same congressional district. Selection of all nongovernment members of the council shall be made with due diligence to ensure membership thereon by persons representing all cultural, demographic, and ethnic segments of the population of the state. Nongovernment members of the council shall be appointed for terms of three years each, except that of the members first appointed, three members shall be appointed for terms of one year, three members for terms of two years, and two members for terms of three years. Members shall be eligible for reappointment for a second three-year term. Vacancies shall be filled in the same manner as the original appointments for the duration of the unexpired term. The board shall appoint a chairman of
the council who shall serve at the will and pleasure of
the board.

(c) The presence of a majority of the members of the
council shall constitute a quorum for the transaction of
business. The council shall elect from among its
members a vice chairman and such other officers as are
necessary. The council shall meet no less than four times
during the calendar year, and additional meetings shall
be held upon a call of the chairman or a majority of the
members, or the board.

(d) The council shall serve as an advisory body to the
board on the development of health care cost contain-
ment policy, strategies and methods, and shall review
and from time to time make recommendations in regard
thereto and on state-of-the-art concepts in health care
policy at the national, state and local level and their
application to the deliberations of the board. The council
shall serve as a conduit for the collection and transmis-
son of information to the board regarding the conse-
quences of board policy upon health care cost contain-
ment and upon hospitals that are subject to the
provisions of this article. The council shall serve as a
means of coordinating health care cost containment
policy among departments of state government. The
council shall review decisions of the board and make
public comments thereon as it sees fit.

(e) In order to assist with the council's deliberations,
the board's staff 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 council shall pay
particular attention to the economic and health status
impact of such efforts on purchasers or classes of
purchasers, particularly the elderly and those on low or
fixed incomes.

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

(g) The board shall consider any recommendations of the council regarding additions or modifications to the board's rate setting and cost containment responsibilities as well as other responsibilities under the board's purview.

(h) The council shall make its own report to the board, the governor and the Legislature within thirty days of the close of each fiscal year. This report shall include summaries of all meetings of the council and any public comments on board decisions, together with any suggestions and policy recommendations.

(i) Council members shall be reimbursed from the board funds for sums necessary to carry out its responsibilities and for reasonable travel expenses to attend council meetings.

§16-29B-7. Staff.

(a) The board may employ such persons as may be necessary to effect the provisions of this article. The board shall set the respective salaries or compensations of all staff. Any person employed by the board 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.

(b) The board shall appoint general counsel who shall act as legal counsel to the board. The general counsel shall serve at the will and pleasure of the board:

(1) The general counsel may act to bring and to defend actions on behalf of 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 the board. The staff shall represent itself in all such actions before the board.
(C) The board may contract with third parties, including state agencies, for any services that may be necessary to perform the duties imposed upon it by this article where such contractual agreements will promote economy, avoid duplication of effort or make the best use of available expertise.

(d) 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 with the director of the division of personnel no later than the first day of July, one thousand nine hundred ninety-one, and thereafter as necessary.

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

(a) In addition to the powers granted to the board elsewhere in this article, the board may:

(1) Adopt, amend and repeal necessary, appropriate and lawful policy guidelines, rules and regulations in accordance with article three, chapter twenty-nine-a of this code: Provided, That subsequent amendments and modifications to any 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 services in hospitals subject to the provisions of this article and may subpoena witnesses, papers, records, documents and all other data in connection therewith. The board 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, and shall in no
respect inure to the private benefit of a board member,
staff member, donor or contracting party;

(4) Lease, rent, acquire, purchase, own, hold, con-
struct, equip, maintain, operate, sell, encumber and
assign rights or dispose of any property, real or
personal, consistent with the objectives of the board 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 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 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 board and its staff.

(c) Each hospital subject to the provisions of this
article shall be assessed by the board on a pro rata basis
using the gross revenues 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 board except that
in no case shall the hospital’s obligation exceed one tenth
of one percent of its gross 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) During the board's start-up period, before the first day of July, one thousand nine hundred eighty-four, each hospital subject to the provisions of this article shall be assessed by the board on a pro rata basis using the gross revenues of each hospital as reported under the provisions of article five-f, chapter sixteen of this code. Within sixty days of passage of this article, the department of health shall notify each hospital of the amount of such fee, which in no case shall exceed one tenth of one percent of the gross revenue of each hospital, the total amount of which fees shall not in any event exceed five hundred thousand dollars during said start-up period. Such fees shall be paid into the aforementioned special fund in two equal installments, the first of which shall be paid on the first day of April, one thousand nine hundred eighty-three, the second of which shall be paid on the first day of January, one thousand nine hundred eighty-four.

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

(f) The board is empowered to withhold rate approvals if any such fees remain unpaid.

§16-29B-18. Hospital and related organizations' annual financial reporting.

(a) It shall be the duty of every hospital which comes under the jurisdiction of this article to file with the board the following financial statements or reports in a form and at intervals specified by the board, 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 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 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 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 in a form specified by the board.

(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 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 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 hospital or related organization under the provisions of this section, the board may require a full or partial audit of the records of the hospital or related organization.

§16-29B-19a. Additional legislative findings and directives.

The Legislature hereby finds and declares that a cost-based rate review system is more effective in containing the cost of acute care hospital services than a revenue-based system. Accordingly, the Legislature directs the board to create a task force to advise the board on the development of a methodology to implement a cost-based rate review system. One member of the task force shall be designated by the governor, one member shall be designated by the president of the Senate, one member shall be designated by the speaker of the House of Delegates, and six members of the task force shall be appointed by the board. The board shall develop a cost-based rate review system and shall adopt regulations to implement the cost-based rate review methodology by the first day of July, one thousand nine hundred ninety-two: Provided, That the board shall file a report with the governor, the president of the Senate, and the speaker of the House of Delegates by the first day of December, one thousand nine hundred ninety-one, which shall outline the status of the development of the cost-based rate review methodology. Regulations promulgated by the board to implement the cost-based rate review system shall be exempt from the requirements of article three, chapter twenty-nine-a of this code. Upon implementation of the regulations, the task force shall be dissolved.
The Legislature further directs the board to implement the utilization review and quality assurance program established by section twenty-three of this article.

The Legislature further finds and directs that the hospital cost containment methodology-phase one adopted by the board effective the twenty-eighth day of May, one thousand nine hundred eighty-five, and approved by the Legislature effective the eighth day of March, one thousand nine hundred eighty-six, shall remain in effect during the development period of the cost based rate review system.

The Legislature further finds and declares that discounts to third-party payors by hospitals have contributed to cost shifting thereby increasing the cost of acute care hospital services to purchasers and other third-party payors. Accordingly, the Legislature directs that every hospital who contracts with a third party payor for the payment of patient care services shall file with the board a copy of every contract in force on the first day of January, one thousand nine hundred ninety-one. No third party payor shall be entitled to a greater discount than the discount specified in any contract in effect on the first day of January, one thousand nine hundred ninety-one unless a subsequent contract is approved by the board pursuant to the provisions of section twenty of this article.

The Legislature further directs the board to examine the problems associated with health care costs in this state, including those associated with discount contracts and the shifting of costs, and file a report with the governor, the president of the Senate, and the speaker of House of Delegates on or before the first day of January, one thousand nine hundred ninety-two, which outlines the problems and which includes recommendations for legislative action to resolve the problems identified. This report shall include a separate examination of those problems associated with hospitals located within twenty miles of the borders of this state and separate recommendations on resolving those problems.
§16-29B-20. Rate determination.

(a) Upon commencement of review activities, no rates may be approved by the board nor payment be made for services provided by hospitals under the jurisdiction of the board by any purchaser or third-party payor to or on behalf of any purchaser or class of purchasers unless:

(1) The costs of the hospital’s services are reasonably related to the services provided and the rates are reasonably related to the costs;

(2) The rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or regulations conflict with this requirement. On and after the effective date of this section, a summary of every proposed contract for the payment of patient care services between a purchaser or third party payor and a hospital shall be filed by the hospital with its rate application for review by the board. No contract for the payment of patient care services between a purchaser or third party payor and a hospital which establishes discounts to the purchaser or third party payor shall take effect until it is approved by the board. The board shall approve or deny the proposed contract within the overall rate review period established in section twenty-one of this article. No discount shall be approved by the board which constitutes an amount below the actual cost to the hospital.

The hospital shall demonstrate to the board that the cost of any discount contained in the contract will not be shifted to any other purchaser or third party payor. The hospital shall further demonstrate that the discount will not result in a decrease in its proportion of medicare, medicaid or uncompensated care patients. In addition, the hospital shall demonstrate to the board that the discount is based upon criteria which constitutes a quantifiable economic benefit to the hospital. All information submitted to the board shall be certified by the hospital administrator as to its accuracy and truthfulness.
(3) The rates of payment for medicaid are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provisions of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality;

(4) The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board; and

(5) In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in such hospital's gross revenues for either rate-setting or assessment purposes.

(b) In the interest of promoting efficient and appropriate utilization of hospital services the board shall review and make findings on the appropriateness of projected gross revenues for a hospital as such revenues relate to charges for services and anticipated incidence of service. The board shall further render a decision as to the amount of net revenue over expenditures that is appropriate for the effective operation of the hospital.

(c) When applying the criteria set forth above, the board shall consider all relevant factors, including, but not limited to, the following: The economic factors in the hospital's area; the hospital's efforts to share services; the hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the health status of those served; the efficiency of the hospital as to cost and delivery of health care; the quality of care; occupancy level; a fair return on invested capital, not otherwise compensated for; whether the hospital is operated for profit or not for profit; costs of education; and, income from any investments and assets not associated with patient care, including, but not limited to, parking garages, residen-
(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article shall not be subject to review unless the board first determines that such wages, salaries and benefits may be unreasonably or uncustomarily high or low. Said exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. “Nonsupervisory personnel,” for the purposes of this section, means, but is not limited to, employees of hospitals subject to the provisions of this article who are paid on an hourly basis.

(e) Reimbursement of capital and operating costs for new services and capital projects subject to article two-d of this chapter shall not be allowed by the board if such costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved by the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four, pursuant to the provisions of article two-d of this chapter.

(f) The board shall consult with relevant licensing agencies and may require them to provide written findings with regard to their statutory functions and information obtained by them in the pursuit of those functions. Any licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the board together with any findings.

(g) Rates shall be set by the board in advance of the year during which they apply except for the procedure set forth in subsection (c), section twenty-one of this article and shall not be adjusted for costs actually incurred.

(h) All determinations, orders and decisions of the board with respect to rates and revenues shall be prospective in nature.
(i) No hospital may charge for services at rates in excess of those established in accordance with the requirements of and procedures set forth in this article.

(j) Notwithstanding any other provision of this article, the board shall approve all requests for rate increases by hospitals which are licensed for one hundred beds or less and which are not located in a standard metropolitan statistical area where the rate of increase is equal to or less than the lowest rate of inflation as established by a recognized inflation index for either the national or regional hospital industry. The board may, by regulation, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted herein.

(k) Notwithstanding any other provision of this article, the board shall develop an expedited review process applicable to all hospitals licensed for more than one hundred beds or that are located in a standard metropolitan statistical area for rate increase requests which may be based upon a recognized inflation index for the national or regional hospital industry.

§16-29B-21. Procedure for obtaining initial rate schedule; adjustments and revisions of rate schedules.

(a) No hospital subject to this article may change or amend its schedule of rates except in accordance with the following procedures:

(1) Any request for a change in rate schedules or other changes must be filed in writing to the board with such supporting data as the hospital seeking to change its rates considers appropriate, in the form prescribed by the board. Upon receipt of notice, the board, if it considers necessary, may hold a public hearing on the proposed change. Such hearing shall be held no later than forty-five days after receipt of the notice. The review of the proposed change may not exceed an overall period of one hundred eighty days from the date of filing to the date of the board’s order. If the board fails to complete its review of the proposed change within the time period specified for the review, the proposed
change shall be deemed to have been approved by the board. Any proposed change shall go into effect upon the date specified in the order. The review period is complete upon the date of the board's final order notwithstanding an appeal of the order to the agency of the state designated by the governor, a circuit court, or the supreme court of appeals by an affected party;

(2) Each hospital shall establish, in a written report which shall be incorporated into each proposed rate application, that it has thoroughly investigated and considered:

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

(b) State-of-the-art advances in health care cost containment, hospital management and rate design, as alternatives to or in mitigation of any rate increase, or service 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;

(c) Implementation of cost control systems, including the elimination of unnecessary or duplicative facilities and services, promotion of alternative forms of care, and other cost control mechanisms;

(d) Initiatives to create alternative delivery systems; and

(e) Efforts to encourage third-party payors, including, but not limited to, insurers, health service, care and maintenance organizations, to control costs, including a combination of education, persuasion, financial incentives and disincentives to control costs;

(3) In the event the board modifies the request of a hospital for a change in its rates so that the hospital obtains only a partial increase in its rate schedule, the hospital shall have the right to accept the benefits of the partial increase in rates and charge its purchasers

56 accordingly without in any way adversely affecting or
57 waiving its right to appeal that portion of the decision
58 and order of the board which denied the remainder of
59 the requested rate increase.

60 (b) The board shall allow a temporary change in a
61 hospital's rates which may be effective immediately
62 upon filing and in advance of review procedures when
63 a hospital files a verified claim that such temporary rate
64 changes are in the public interest, and are necessary to
65 prevent insolvency, to maintain accreditation or for
66 emergency repairs or to relieve undue financial hard-
67 ship. The verified claim shall state the facts supporting
68 the hospital's position, the amount of increase in rates
69 required to alleviate the situation, and shall summarize
70 the overall effect of the rate increase. The claim shall
71 be verified by either the chairman of the hospital's
72 governing body or by the chief executive officer of the
73 hospital.

74 (c) Following receipt of the verified claim for tempor-
75 ary relief, the board shall review the claim through its
76 usual procedures and standards; however, this power of
77 review does not affect the hospital's ability to place the
78 temporary rate increase into effect immediately. The
79 review of the hospital's claim shall be for a permanent
80 rate increase and the board may include such other
81 factual information in the review as may be necessary
82 for a permanent rate increase review. As a result of its
83 findings from the permanent review, the board may
84 allow the temporary rate increase to become permanent,
85 to deny any increase at all, to allow a lesser increase,
86 or to allow a greater increase.

87 (d) When any change affecting an increase in rates
88 goes into effect before a final order is entered in the
89 proceedings, for whatever reasons, where it deems it
90 necessary and practicable, the board may order the
91 hospital to keep a detailed and accurate account of all
92 amounts received by reason of the increase in rates and
93 the purchasers and third-party payors from whom such
94 amounts were received. At the conclusion of any
95 hearing, appeal or other proceeding, the board may
96 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 condi-
tions determined by the board, charge over and amor-
tize 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.

(e) The board, upon a determination that a hospital
has overcharged purchasers or charged purchasers at
rates not approved by the board 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.

(f) The board may open a proceeding against any
hospital at any time with regard to compliance with
rates approved and the efficiency and effectiveness of
the care being rendered in the hospital.

§16-29B-28. Termination date.

Pursuant to the provisions of section four, article ten,
chapter four of this code, the health care cost review
authority shall continue to exist until the first day of
July, one thousand nine hundred ninety-seven, to allow
for a completion of an audit by the Joint Committee on
Government Operations.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the ___ day of ____________, 1991.

Governor
PRESENTED TO THE
GOVERNOR
Date 3/20/91
Time 11:35 AM