WEST VIRGINIA LEGISLATURE
REGULAR SESSION, 1997

ENROLLED
Committee Substitute for
SENATE BILL NO. 458

(By Senators Tomsic, Mr. President, and Backlew,
By Request of the Executive)

PASSED April 12, 1997
In Effect NINETY DAYS FROM PASSAGE
AN ACT to repeal section sixteen, article twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended; and to amend and reenact sections one, two, three, five, eight, nine, eleven, seventeen, eighteen, nineteen, nineteen-a, twenty, twenty-three, twenty-five, twenty-six, twenty-seven and twenty-eight of said article; and to further amend said article by adding thereto a new section, designated section six, all relating to the West Virginia health care authority; including additional legislative findings and purpose; changing the agency's title; amending and adding certain definitions; amending conflicting employment prohibition
for board members and former board members to comply with the governmental ethics act; deleting the review council; authorizing information gathering and coordination; creating a data advisory group and expanding the board's powers generally; changing annual reporting requirements; related programs and priorities; including utilization reporting with uniform system of accounts and financing; defining entities subject to annual reporting requirements; requiring review and reporting for alternatives to present rate-setting; legislative directives, studies, findings and recommendations; explaining discount and risk-bearing contract review and authorizing promulgation of rules, creating a quality assurance advisory group; modifying public disclosure, exemptions from state antitrust laws and penalties for violations to include health care providers; and extending termination date.

Be it enacted by the Legislature of West Virginia:

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twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be repealed; and that sections one, two, three, five, eight, nine, eleven, seventeen, eighteen, nineteen, nineteen-a, twenty, twenty-three, twenty-five, twenty-six,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

ARTICLE 29B. HEALTH CARE AUTHORITY.

§16-29B-1. Legislative findings; purpose.

The Legislature hereby finds and declares that the health and welfare of the citizens of this state is being threatened by unreasonable increases in the cost of health care services, a fragmented system of health care, lack of integration and coordination of health care services, unequal access to primary and preventative care, lack of a comprehensive and coordinated health information system to gather and disseminate data to promote the availability of cost-effective, high-quality services and to permit effective health planning and analysis of utilization, clinical outcomes and cost and risk factors. In order to alleviate these threats: (1) Information on health care
costs must be gathered; (2) a system of cost control must
be developed; and (3) an entity of state government must
be given authority to ensure the containment of health
care costs, to gather and disseminate health care informa-
tion; to analyze and report on changes in the health care
delivery system as a result of evolving market forces,
including the implementation of managed care; and to
assure that the state health plan, certificate of need
program, rate regulation program and information
systems serve to promote cost containment, access to care,
quality of services and prevention. Therefore, the purpose
of this article is to protect the health and well-being of the
citizens of this state by guarding against unreasonable loss
of economic resources as well as to ensure the continua-
tion of appropriate access to cost-effective, high-quality
health care services.

§16-29B-2. Short title.

This article may be cited as the “West Virginia Health Care Authority”.

§16-29B-3. Definitions.

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

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

(a) “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. Exam-
pies of classes of purchasers are medicare beneficiaries,
urban 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 authority, an autonomous
division within the state department of health and human
resources;

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

(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 govern-
ment which is primarily engaged in providing to inpa-
tients, by or under the supervision of physicians, diagnos-
tic and therapeutic services for medical diagnosis, treat-
ment 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, partner-
ship, committee, corporation, association or other organi-
zation such as a joint stock company, a state or political
subdivision or instrumentality thereof or any legal entity
recognized by the state;

(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 health care provider, but does not include
third-party payers;

(h) "Rates" means all value given or money payable to
health care providers 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 health care providers; and

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

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

The "West Virginia Health Care Cost Review Authority", heretofore created as an autonomous division of the department of health, is hereby continued as an autonomous division of the department of health and human resources and shall be known as the "West Virginia Health Care Authority", hereinafter referred to as the board. Any references in this code to the West Virginia health care cost review authority shall mean the West Virginia health care authority.

(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 or her office, take and subscribe to the oath provided by section five, article IV of the constitution of the state of West Virginia, which oath shall be filed in the office of the secretary of state. The governor shall designate one of the board members to serve as chairman at the governor's will and pleasure. The chairman shall be the chief administrative officer of the board. 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 twelfth day of March, one thousand nine hundred eighty-three. 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 or health care provider 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 third-party payor or health care provider. 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 or former board member may accept employment with any hospital or health care provider subject to the jurisdiction
of the board in violation of the West Virginia government-
tal ethics act, chapter six-b of this code: *Provided, That* such act shall not apply to employment accepted after

termination of the board.

(d) The concurrent judgment of two of the board mem-
bers 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 sixty-five thousand dollars and the annual salary
of the other board members shall be sixty thousand
dollars.

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

(a) The board shall: Coordinate and oversee the health
data collection of state agencies; lead state agencies’
efforts to make the best use of emerging technology to
effect the expedient and appropriate exchange of health
care information and data, including patient records and
reports; and coordinate data base development, analysis
and reporting to facilitate cost management, utilization
review and quality assurance efforts by state payor and
regulatory agencies, insurers, consumers, providers and
other interested parties. Agencies of the state collecting
health data shall work together through the board to
develop an integrated system for the efficient collection,
responsible use and dissemination of such data and to
facilitate and support the development of statewide health
information systems that will allow for the electronic
transmittal of all health information and claims process-
ing activities of state agencies within the state and that
will coordinate the development and use of electronic
health information systems within state government. The
board shall establish minimum requirements and issue
reports relating to information systems of all state health
programs, including simplifying and standardizing forms, establishing information standards and reports for capitated managed care programs to be managed by the insurance commission, and shall develop a comprehensive system to collect ambulatory health care data. The board is authorized to gain access to any health-related data base in state government for the purposes of fulfilling its duties: Provided, That, for any data base to which the board gains access, the use and dissemination of information from the data base shall be subject to the confidentiality provisions applicable to such data base.

(b) To advise the board in its efforts under this section, the board shall create a data advisory group and appoint one of the board's members as chair of the group. The group shall be composed of representatives of consumers, businesses, providers, payors and state agencies. The data advisory group shall assist the board in developing priorities and protocols for data collection and the development and reform of health information systems provided under this section.

c) The board's staff shall gather information on cost containment efforts, including, but not limited to, the provision of alternative delivery systems, prospective payment systems, alternative rate-making methods, and programs of consumer education. The board shall pay particular attention to the economic, quality of care and health status impact of such efforts on purchasers or classes of purchasers, particularly the elderly and those on low or fixed incomes.

(d) The board's staff shall further gather information on state-of-the-art advances in medical technology, the cost effectiveness of such advances and their impact on advances in health care services and management practices, and any other state-of-the-art concepts relating to health care cost containment, health care improvement or other issues the board finds relevant and directs staff to investigate. The board's staff shall prepare and keep a register of such information and update it on an annual basis.
§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 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 health care services subject to the provisions of this article and may subpoena witnesses, papers, records, documents and all other data in connection therewith. The board 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, construct,
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 design-
ated "health care cost review fund", with the moneys in
such fund being expendable after appropriation by the
Legislature for purposes consistent with this article. Any
balance remaining in said fund at the end of any fiscal
year shall not revert to the treasury, but shall remain in
said fund and such moneys shall be expendable after
appropriation by the Legislature in ensuing fiscal years.

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

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

§16-29B-9. Annual report.

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

§16-29B-11. Related programs.

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

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

(a) The board shall develop and specify a uniform system of reporting utilization, accounting and financial reporting, including cost allocation methods by which hospitals shall record their revenues, income, expenses, capital outlays, assets, liabilities and units of service. The development and specification process aforementioned shall be conducted in a manner determined by the board to be
most efficient for that purpose notwithstanding the
provisions of chapter twenty-nine-a of this code. Each
hospital shall adopt this uniform system for the purpose of
reporting utilization, costs and revenues to the board
effective for the fiscal year beginning on or after twelve
months from the effective date of this article.

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

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

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

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

§16-29B-18. Annual reporting.

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

(1) A balance sheet detailing the assets, liabilities and
(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 health care provider or related organization under the provisions of this section, the board may require a full or partial audit of the records of the health care provider or related organization.

§16-29B-19. Rate-setting powers generally.

(a) The board shall have power: (1) To initiate reviews and investigations of hospital rates and establish and approve such rates; (2) to initiate reviews and investigations of hospital rates for specific services and the component factors which determine such rates; (3) to initiate reviews and investigations of hospital budgets and the specific components of such budgets; and (4) to approve or disapprove hospital rates and budgets taking into consideration the criteria set forth in section twenty of this article.

(b) In the interest of promoting the most efficient and effective use of hospital service, the board may adopt and approve alternative methods of rate determination. The board may also adopt methods of charges and payments of an experimental nature which are in the public interest and consistent with the purpose of this article.

(c) The board shall examine the need for an alternative to the current rate-setting method as a means of controlling hospital costs and submit the findings, recommendations and any proposed drafts of legislation, if necessary, in a report to the legislative oversight commission on health and human resources accountability and the governor on or before the first day of August, one thousand nine hundred ninety-eight.

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

(a) The Legislature finds and declares that changing market forces require periodic changes in the regulatory structure for health care providers and hereby directs the board to study the following:
(1) The certificate of need program, including the effect of any changes on managed care and access for uninsured and rural consumers; determining which services or capital expenditures should be exempt and why; and the status of similar programs in other states;

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

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

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

(b) The board may form task forces to assist it in addressing these issues and it shall prepare a report on its findings and recommendations, which is to be filed with the governor, the president of the Senate and the speaker of the House of Delegates on or before the first day of October, one thousand nine hundred ninety-eight, identifying each problem and recommendation with specificity and the effect of each recommendation on cost, access and quality of care. The task forces, if formed, shall be composed of representatives of consumers, businesses, providers, payors and state agencies.

(c) The board shall report quarterly to the legislative oversight commission on health and human resources accountability regarding the appointment, direction and progress of the studies.

§16-29B-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 reason-
ably related to the costs;

(2) The rates are equitably established among all pur-
chasers or classes of purchasers within a hospital without
discrimination unless federal or state statutes or rules and
regulations conflict with this requirement. On and after
the effective date of this section, a summary of every
proposed contract, or amendment to any existing contract,
for the payment of patient care services between a pur-
chaser or third-party payor and a hospital shall be filed by
the hospital for review by the board, which reviews shall
occur no less frequently than each calendar quarter: (A)
If the contract establishes a discount to the purchaser or
third-party payor, it shall not take effect until approved
by the board. For purposes of this article, a risk-bearing
contract is reviewable as a discount contract and the
amount computed as the discount percentage by the
provider on the board shall be the approved amount of the
discount. The difference, if any, between the actual
discount percentage and amount and the approved
amount, shall not be considered for rate-setting purposes;
(B) the board may promulgate rules, in accordance with
the provisions of section eight of this article, that establish
the criteria for review of discount contracts, which shall
include that: (i) No discount shall be approved by the
board which constitutes an amount below the cost to the
hospital; (ii) the cost of any discount contained in the
contract will not be shifted to any other purchaser or
third-party payor; (iii) the discount will not result in a
decline in the hospital’s average number of medicare,
medicaid or uncompensated care patients served during
the previous three fiscal years; and (iv) the discount is
based upon criteria which constitutes a quantifiable
economic benefit to the hospital. The board may define by
rule what constitutes “cost” in subparagraphs (i) and (ii)
of this paragraph; “purchaser” in subparagraph (iii) of
this paragraph; and “economic benefit” in subparagraph
(iv) of this paragraph. Any rules promulgated pursuant to
this subsection may be filed as emergency rules. All
information submitted to the board shall be certified by
the hospital’s chief executive officer and chief financial
officer 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 the 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 the revenues relate to charges for services and anticipated incidence of service.

(c) When applying the criteria set forth in subsections (a) and (b) of this section, 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, residences, office buildings, and income from related organizations and restricted funds.
whether or not associated with patient care.

(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article are not subject to review unless the board first determines that the wages, salaries and benefits may be unreasonably or uncustomarily high or low. This exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. The term “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 the costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved: (i) By the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four; or (ii) thereafter, 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) A hospital shall file a complete rate application with the board on an annual basis a minimum of seventy-five days prior to the beginning of its fiscal year. If the application is filed and determined to be complete by the board sixty days prior to the beginning of the hospital’s fiscal year, and no hearing is requested on the application, the board shall set the rates in advance of the year during which they apply and shall not adjust the rates for costs actually incurred. Provided, That if the board does not establish rates by the beginning of the hospital’s fiscal
year, and a hearing has not been requested, the board shall establish rates retroactively to the beginning of the hospital’s fiscal year: Provided, however, That if the board does not establish rates by the beginning of the hospital’s fiscal year, and a hearing has been requested, the board may establish rates retroactively to the beginning of the fiscal year. This subsection shall not apply to the procedure set forth in subsection (c), section twenty-one of this article.

(h) 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.

(i) 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 rule, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted in this section.

(j) 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.

(k) The board may require hospitals to file such additional information as it deems necessary to evaluate a market-driven system of rate setting.

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

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

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

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

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

§16-29B-25. Public disclosure.

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 health care provider subject to the provisions of this article or any other appropriate related matters, and it shall be empowered to publish and disseminate any information which would be useful to members of the general public in making informed choices about health care providers.

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

Actions of the board shall be exempt from antitrust action as provided in section five, article eighteen, chapter forty-seven of this code. Any actions of health care providers under the board’s jurisdiction, when made in compliance with orders, directives, rules or regulations issued or promulgated by the board, shall likewise be exempt. Health care providers shall be subject to the antitrust guidelines of the federal trade commission and
§16-29B-27. Penalties for violations.

1 In addition to civil remedies set forth, any person or health care provider violating any provision of this article or any valid order or rule lawfully established hereunder shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than one thousand dollars. Each day of a continuing violation after conviction shall be considered a separate offense. No fines assessed may be considered part of the hospital's costs in the regulation of its rates.

§16-29B-28. Termination date.

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

[Signature]
Chairman Senate Committee

[Signature]
Chairman House Committee

Originated in the Senate.

In effect ninety days from passage.

[Signature]
Clerk of the Senate

[Signature]
Clerk of the House of Delegates

[Signature]
President of the Senate

[Signature]
Speaker House of Delegates

The within is approved this the ___ day of ________, 1997.

[Signature]
Governor
PRESENTED TO THE
GOVERNOR
Date 4/28/97
Time 2:40pm