

WEST VIRGINIA LEGISLATURE

2017 REGULAR SESSION

2017 APR 10 P 3:28

OFFICE WEST VIRGINIA
SECRETARY OF STATE

ENROLLED

Committee Substitute

for

House Bill 2459

BY DELEGATES ELLINGTON, SUMMERS, ROHRBACH AND

HOLLEN

[Passed March 30, 2017; in effect from passage.]

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1 AN ACT to repeal §16-2D-5f of the Code of West Virginia, 1931, as amended; to repeal §16-5F-
2 1; §16-5F-2, §16-5F-3, §16-5F-4, §16-5F-5, §16-5F-6 and §16-5F-7; to repeal §16-29B-
3 6, §16-29B-7, §16-29B-9, §16-29B-10, §16-29B-11, §16-29B-17, §16-29B-18, §16-29B-
4 22, §16-29B-23, §16-29B-24, §16-29B-25, §16-25B-27, and §16-29B-29; to repeal §16-
5 29I-1, §16-29I-2, §16-29I-3, §16-29I-4, §16-29I-5, §16-29I-6, §16-29I-7, §16-29I-8, §16-
6 29I-9 and §16-29I-10; to amend and reenact §5F-1-3a of said code; to amend and reenact
7 §6-7-2a of said code; to amend and reenact §9-4C-7 and §9-4C-8 of said code; to amend
8 and reenact §11-27-9 and §11-27-11 of said code; to amend and reenact §16-2D-2, §16-
9 2D-3, §16-2D-4, §16-2D-5, §16-2D-8, §16-2D-9, §16-2D-10, §16-2D-11, §16-2D-13, §16-
10 2D-15 and §16-2D-16 of said code; to amend and reenact §16-5B-17 of said code; to
11 amend and reenact §16-29B-2, §16-29B-3, §16-29B-5, §16-29B-8, §16-29B-12, §16-29B-
12 26 and §16-29B-28; to amend said code by adding thereto a new section, designated §16-
13 29B-5a; to amend said code by adding thereto a new section, designated §16-29B-30; to
14 amend said code by adding thereto a new section, designated §16-29G-1a; to amend and
15 reenact §16-29G-4 of said code; to amend and reenact §21-5F-4 of said code; to amend
16 and reenact §33-4A-1, §33-4A-2, §33-4A-3, §33-4A-5, §33-4A-6, and §33-4A-7 of said
17 code; and to amend and reenact §33-16D-16 of said code, all relating to regulation of
18 health care; repealing redundant code section relative to neonatal abstinence facilities;
19 repealing health care facility financial disclosure; repealing uniform system of financial
20 reporting; repealing information gathering and coordination advisory group; updating the
21 certificate of need process; placing certificate of need under Secretary of Department of
22 Health and Human Resources; defining terms; adding exemptions to certificate of need;
23 clarifying exemptions; modifying computed technology exemption from certificate of need;
24 clarifying skilled nursing facility exemption for counties with no skilled nursing facility;

25 allowing skilled nursing facility bed transfers; requiring skilled nursing facility beds retain
26 identical certification status; clarifying appeals process; removing autonomy of Health
27 Care Authority; placing Health Care Authority under direct supervision of Secretary of the
28 Department of Health and Human Resources; repealing unnecessary code sections made
29 unnecessary with transfer to Department of Health and Human Resources; eliminating
30 powers related to insurance policies and health organizations; modifying health care
31 provider tax relative to rate review; eliminating public disclosure; eliminating granting
32 authority; eliminating unnecessary penalties; eliminating unnecessary severability section;
33 eliminating three full time board members; replacing existing board with a five member
34 board; appointment of board members; setting out qualifications of board members;
35 setting out terms of offices, filling of vacancies and oath for board members; providing for
36 payment of board member expenses; providing for appointment of a chairman; setting out
37 meeting requirements; creating the position of Executive Director; setting out power and
38 duties of the Executive Director; setting compensation for the Executive Director;
39 eliminating certain powers of the Health Care Authority; eliminating hospital and health
40 care facility assessments; updating authority power relative to cooperative agreements;
41 providing for transfer of necessary duties of Health Care Authority to Department of Health
42 and Human Resources; requiring a transition plan; setting forth necessary elements of
43 transition plan; allowing transfer of West Virginia Health Information Network to private
44 entity; granting access to West Virginia Health Information Network to Secretary of
45 Department of Health and Human Resources; providing for transfer of encumbered
46 amounts of West Virginia Health Information Network to private entity upon transfer date;
47 providing for administrative penalties for nurses overtime be paid into the general revenue
48 fund; eliminating discretionary spending of Health Care Authority for amounts from

49 penalties for violation of the nurse overtime act; substituting executive director of Health
50 Care Authority or Secretary of Department of Health and Human Resources for chair of
51 Health Care Authority in various code sections; transferring authority of Health Care
52 Authority regarding uninsured small group health benefit plans to the Insurance
53 Commission; eliminating archaic revolving loan and grant fund; making conforming
54 amendments; and setting effective dates.

Be it enacted by the Legislature of West Virginia:

1 That §16-2D-5f of the Code of West Virginia, 1931, as amended, be repealed; that §16-
2 5F-1; §16-5F-2, §16-5F-3, §16-5F-4, §16-5F-5, §16-5F-6 and §16-5F-7 be repealed; that §16-
3 29B-6, §16-29B-7, §16-29B-9, §16-29B-10, §16-29B-11, §16-29B-17, §16-29B-18, §16-29B-22,
4 §16-29B-23, §16-29B-24, §16-29B-25, §16-25B-27, and §16-29B-29 be repealed; that §16-29I-
5 1, §16-29I-2, §16-29I-3, §16-29I-4, §16-29I-5, §16-29I-6, §16-29I-7, §16-29I-8, §16-29I-9 and
6 §16-29I-10 be repealed; that §5F-1-3a of said code be amended and reenacted; that §6-7-2a of
7 said code be amended and reenacted; that §9-4C-7 and §9-4C-8 of said code be amended and
8 reenacted; that §11-27-9 and §11-27-11 of said code be amended and reenacted; that §16-2D-
9 2, §16-2D-3, §16-2D-4, §16-2D-5, §16-2D-8, §16-2D-9, §16-2D-10, §16-2D-11, §16-2D-13, §16-
10 2D-15 and §16-2D-16 of said code be amended and reenacted; that §16-5B-17 of said code be
11 amended and reenacted; that §16-29B-2, §16-29B-3, §16-29B-5, §16-29B-8, §16-29B-12, §16-
12 29B-26 and §16-29B-28; that said code be amended by adding thereto a new section, designated
13 §16-29B-5a; that said code be amended by adding thereto a new section, designated §16-29B-
14 30; that said code be amended by adding thereto a new section, designated §16-29G-1a; that
15 §16-29G-4 of said code be amended and reenacted; that §21-5F-4 of said code be amended and
16 reenacted; that §33-4A-1, §33-4A-2, §33-4A-3, §33-4A-5, §33-4A-6, and §33-4A-7 of said code
17 be amended and reenacted; and that §33-16D-16 of said code be amended and reenacted, all to
18 read as follows:

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

ARTICLE 1. GENERAL PROVISIONS.

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

1 There is hereby created an executive compensation commission composed of three
2 members, one of whom shall be the secretary of administration, one of whom shall be appointed
3 by the Governor from the names of two or more nominees submitted by the President of the
4 Senate, and one of whom shall be appointed by the Governor from the names of two or more
5 nominees submitted by the Speaker of the House of Delegates. The names of such nominees
6 shall be submitted to the Governor by not later than June 1, 2000, and the appointment of such
7 members shall be made by the Governor by not later than July 1, 2000. The members appointed
8 by the Governor shall have had significant business management experience at the time of their
9 appointment and shall serve without compensation other than reimbursement for their reasonable
10 expenses necessarily incurred in the performance of their commission duties. For the 2001
11 regular session of the Legislature and every four years thereafter, the commission shall review
12 the compensation for cabinet secretaries and other appointed officers of this state, including, but
13 not limited to, the following: Commissioner, Division of Highways; commissioner, Bureau of
14 Employment Programs; director, Division of Environmental Protection; commissioner, Bureau of
15 Senior Services; director of tourism; commissioner, division of tax; administrator, division of
16 health; commissioner, Division of Corrections; director, Division of Natural Resources;
17 superintendent, state police; administrator, lottery division; director, Public Employees Insurance
18 Agency; administrator, Alcohol Beverage Control Commission; commissioner, Division of Motor
19 Vehicles; director, Division of Personnel; Adjutant General; the Executive Director of the Health
20 Care Authority; director, Division of Rehabilitation Services; executive director, educational
21 broadcasting authority; executive secretary, Library Commission; chairman and members of the
22 Public Service Commission; director of emergency services; administrator, division of human

23 services; executive director, Human Rights Commission; director, division of Veterans Affairs;
24 director, office of miner's health safety and training; commissioner, Division of Banking;
25 commissioner, division of insurance; commissioner, Division of Culture and History;
26 commissioner, Division of Labor; director, Prosecuting Attorneys Institute; director, Board of Risk
27 and Insurance Management; commissioner, oil and gas conservation commission; director,
28 geological and economic survey; executive director, water development authority; executive
29 director, Public Defender Services; director, state rail authority; chairman and members of the
30 Parole Board; members, employment security review board; members, workers' compensation
31 appeal board; chairman, Racing Commission; executive director, women's commission; and
32 director, hospital finance authority.

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

CHAPTER 6. GENERAL PROVISIONS RESPECTING OFFICERS.

ARTICLE 7. COMPENSATION AND ALLOWANCES.

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

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

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

10 Commissioner, Division of Highways, \$92,500; Commissioner, Division of Corrections,
11 \$80,000; Director, Division of Natural Resources, \$75,000; Superintendent, State Police,
12 \$85,000; Commissioner, Division of Banking, \$75,000; Commissioner, Division of Culture and
13 History, \$65,000; Commissioner, Alcohol Beverage Control Commission, \$75,000;
14 Commissioner, Division of Motor Vehicles, \$75,000; Director, Human Rights Commission,
15 \$55,000; Commissioner, Division of Labor, \$70,000; prior to July 1, 2011, Director, Division of
16 Veterans Affairs, \$65,000; Chairperson, Board of Parole, \$55,000; members, Board of Parole,
17 \$50,000; members, Employment Security Review Board, \$17,000; and Commissioner, Workforce
18 West Virginia, \$75,000. Secretaries of the departments shall be paid an annual salary as follows:
19 Health and Human Resources, \$95,000: *Provided*, That effective July 1, 2013, the Secretary of
20 the Department of Health and Human Resources shall be paid an annual salary not to exceed
21 \$175,000; Transportation, \$95,000: *Provided, however*, That if the same person is serving as both
22 the Secretary of Transportation and the Commissioner of Highways, he or she shall be paid
23 \$120,000; Revenue, \$95,000; Military Affairs and Public Safety, \$95,000; Administration,
24 \$95,000; Education and the Arts, \$95,000; Commerce, \$95,000; Veterans' Assistance, \$95,000;
25 and Environmental Protection, \$95,000: *Provided further*, That any officer specified in this
26 subsection whose salary is increased by more than \$5,000 as a result of the amendment and
27 reenactment of this section during the 2011 regular session of the Legislature shall be paid the
28 salary increase in increments of \$5,000 per fiscal year beginning July 1, 2011, up to the maximum
29 salary provided in this subsection.

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

32 Director, Board of Risk and Insurance Management, \$80,000; Director, Division of
33 Rehabilitation Services, \$70,000; Director, Division of Personnel, \$70,000; Executive Director,
34 Educational Broadcasting Authority, \$75,000; Secretary, Library Commission, \$72,000; Director,

35 Geological and Economic Survey, \$75,000; Executive Director, Prosecuting Attorneys Institute,
36 \$80,000; Executive Director, Public Defender Services, \$70,000; Commissioner, Bureau of
37 Senior Services, \$75,000; Executive Director, Women's Commission, \$45,000; Director, Hospital
38 Finance Authority, \$35,000; member, Racing Commission, \$12,000; Chairman, Public Service
39 Commission, \$85,000; members, Public Service Commission, \$85,000; Director, Division of
40 Forestry, \$75,000; Director, Division of Juvenile Services, \$80,000; Executive Director, Regional
41 Jail and Correctional Facility Authority, \$80,000 and Executive Director of the Health Care
42 Authority, \$80,000.

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

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

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

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

CHAPTER NINE. HUMAN SERVICES.

ARTICLE 4C. HEALTH CARE PROVIDER MEDICAID ENHANCEMENT ACT.

§9-4C-7. Powers and duties.

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

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

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

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

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

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

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

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

40 (d) In addition to the duties specified in subsection (a) of this section, the ambulance
41 service provider Medicaid board shall develop a method for regulating rates charged by
42 ambulance services.

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

§9-4C-8. Duties of secretary of Department of Health and Human Resources.

1 (a) The secretary, or his or her designee, shall serve on each board created pursuant to
2 this article as an ex officio, nonvoting member and shall keep and maintain records for each
3 board.

4 (b) In relation to outpatient hospital services, the secretary shall furnish information
5 needed for reporting purposes. This information includes, but is not limited to, the following:

6 (1) For each hospital, the amount of payments and related billed charges for hospital
7 outpatient services each month;

8 (2) The percentage of the state's share of Medicaid program financial obligation from time
9 to time as necessary; and

10 (3) Any other financial and statistical information necessary to determine the net effect of
11 any cost shift.

12 (c) The secretary shall determine an appropriate resolution for conflicts arising between
13 the various boards.

14 (d) The secretary shall purchase nationally published fee schedules to be used, if
15 available, as a reference by the Medicaid enhancement boards in developing fee schedules.

CHAPTER 11. TAXATION.

ARTICLE 27. HEALTH CARE PROVIDER TAXES.

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

1 (a) *Imposition of tax.* — For the privilege of engaging or continuing within this state in the
2 business of providing inpatient hospital services, there is hereby levied and shall be collected
3 from every person rendering such service an annual broad-based health care related tax.

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

7 (c) *Definitions.* —

8 (1) "Gross receipts" means the amount received or receivable, whether in cash or in kind,
9 from patients, third-party payors and others for inpatient hospital services furnished by the
10 provider, including retroactive adjustments under reimbursement agreements with third-party
11 payors, without any deduction for any expenses of any kind: *Provided*, That accrual basis
12 providers shall be allowed to reduce gross receipts by their contractual allowances, to the extent
13 such allowances are included therein, and by bad debts, to the extent the amount of such bad
14 debts was previously included in gross receipts upon which the tax imposed by this section was
15 paid.

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

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

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

1 (a) *Imposition of tax.* — For the privilege of engaging or continuing within this state in the
2 business of providing nursing facility services, other than those services of intermediate care
3 facilities for individuals with an intellectual disability, there is levied and shall be collected from
4 every person rendering such service an annual broad-based health care-related tax.

5 (b) *Rate and measure of tax.* — The tax imposed in subsection (a) of this section is five
6 and one-half percent of the gross receipts derived by the taxpayer from furnishing nursing facility
7 services in this state, other than services of intermediate care facilities for individuals with an
8 intellectual disability.

9 (c) *Definitions.* —

10 (1) "Gross receipts" means the amount received or receivable, whether in cash or in kind,
11 from patients, third-party payors and others for nursing facility services furnished by the provider,
12 including retroactive adjustments under reimbursement agreements with third-party payors,

13 without any deduction for any expenses of any kind: *Provided*, That accrual basis providers are
14 allowed to reduce gross receipts by their bad debts, to the extent the amount of those bad debts
15 was previously included in gross receipts upon which the tax imposed by this section was paid.

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

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-2. Definitions.

1 As used in this article:

2 (1) "Affected person" means:

3 (A) The applicant;

4 (B) An agency or organization representing consumers;

5 (C) An individual residing within the geographic area but within this state served or to be
6 served by the applicant;

7 (D) An individual who regularly uses the health care facilities within that geographic area;

8 (E) A health care facility located within this state which provide services similar to the
9 services of the facility under review and which will be significantly affected by the proposed
10 project;

11 (F) A health care facility located within this state which, before receipt by the authority of
12 the proposal being reviewed, has formally indicated an intention to provide similar services within
13 this state in the future;

14 (G) Third-party payors who reimburse health care facilities within this state; or

15 (H) An organization representing health care providers;

16 (2) "Ambulatory health care facility" means a facility that provides health services to
17 noninstitutionalized and nonhomebound persons on an outpatient basis;

18 (3) "Ambulatory surgical facility" means a facility not physically attached to a health care
19 facility that provides surgical treatment to patients not requiring hospitalization;

20 (4) "Applicant" means a person applying for a certificate of need, exemption or
21 determination of review;

22 (5) "Authority" means the West Virginia Health Care Authority as provided in article twenty-
23 nine-b of this chapter;

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

27 (7) "Behavioral health services" means services provided for the care and treatment of
28 persons with mental illness or developmental disabilities;

29 (8) "Birthing center" means a short-stay ambulatory health care facility designed for low-
30 risk births following normal uncomplicated pregnancy;

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

33 (10) "Capital expenditure" means:

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

35 (I) Under generally accepted accounting principles is not properly chargeable as an
36 expense of operation and maintenance; or

37 (II) Is made to obtain either by lease or comparable arrangement any facility or part thereof
38 or any equipment for a facility or part; and

39 (ii) (I) Exceeds the expenditure minimum;

40 (II) Is a substantial change to the bed capacity of the facility with respect to which the
41 expenditure is made; or

42 (III) Is a substantial change to the services of such facility;

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

45 (C) A series of expenditures, if the sum total exceeds the expenditure minimum and if
46 determined by the authority to be a single capital expenditure subject to review. In making this
47 determination, the authority shall consider: Whether the expenditures are for components of a
48 system which is required to accomplish a single purpose; or whether the expenditures are to be
49 made within a two-year period within a single department such that they will constitute a significant
50 modernization of the department.

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

53 (12) "Community mental health and intellectual disability facility" means a facility which
54 provides comprehensive services and continuity of care as emergency, outpatient, partial
55 hospitalization, inpatient or consultation and education for individuals with mental illness,
56 intellectual disability;

57 (13) "Diagnostic imaging" means the use of radiology, ultrasound, mammography;

58 (14) "Drug and Alcohol Rehabilitation Services" means a medically or
59 psychotherapeutically supervised process for assisting individuals through the processes of
60 withdrawal from dependency on psychoactive substances;

61 (15) "Expenditure minimum" means the cost of acquisition, improvement, expansion of
62 any facility, equipment, or services including the cost of any studies, surveys, designs, plans,
63 working drawings, specifications and other activities, including staff effort and consulting at and
64 above \$5 million;

65 (16) "Health care facility" means a publicly or privately owned facility, agency or entity that
66 offers or provides health services, whether a for-profit or nonprofit entity and whether or not
67 licensed, or required to be licensed, in whole or in part;

68 (17) "Health care provider" means a person authorized by law to provide professional
69 health services in this state to an individual;

70 (18) "Health services" means clinically related preventive, diagnostic, treatment or
71 rehabilitative services;

72 (19) "Home health agency" means an organization primarily engaged in providing
73 professional nursing services either directly or through contract arrangements and at least one of
74 the following services:

75 (A) Home health aide services;

76 (B) Physical therapy;

77 (C) Speech therapy;

78 (D) Occupational therapy;

79 (E) Nutritional services; or

80 (F) Medical social services to persons in their place of residence on a part-time or
81 intermittent basis.

82 (20) "Hospice" means a coordinated program of home and inpatient care provided directly
83 or through an agreement under the direction of a licensed hospice program which provides
84 palliative and supportive medical and other health services to terminally ill individuals and their
85 families.

86 (21) "Hospital" means a facility licensed pursuant to the provisions of article five-b of this
87 chapter and any acute care facility operated by the state government, that primarily provides
88 inpatient diagnostic, treatment or rehabilitative services to injured, disabled or sick persons under
89 the supervision of physicians.

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

93 (23) "Like equipment" means medical equipment in which functional and technological
94 capabilities are similar to the equipment being replaced; and the replacement equipment is to be
95 used for the same or similar diagnostic, therapeutic, or treatment purposes as currently in use;
96 and it does not constitute a substantial change in health service or a proposed health service.

97 (24) "Major medical equipment" means a single unit of medical equipment or a single
98 system of components with related functions which is used for the provision of medical and other
99 health services and costs in excess of the expenditure minimum. This term does not include
100 medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory
101 services if the clinical laboratory is independent of a physician's office and a hospital and it has
102 been determined under Title XVIII of the Social Security Act to meet the requirements of
103 paragraphs ten and eleven, Section 1861(s) of such act, Title 42 U.S.C. §1395x. In determining
104 whether medical equipment is major medical equipment, the cost of studies, surveys, designs,
105 plans, working drawings, specifications and other activities essential to the acquisition of such
106 equipment shall be included. If the equipment is acquired for less than fair market value, the term
107 "cost" includes the fair market value.

108 (25) "Medically underserved population" means the population of an area designated by
109 the authority as having a shortage of a specific health service.

110 (26) "Nonhealth-related project" means a capital expenditure for the benefit of patients,
111 visitors, staff or employees of a health care facility and not directly related to health services
112 offered by the health care facility.

113 (27) "Offer" means the health care facility holds itself out as capable of providing, or as
114 having the means to provide, specified health services.

115 (28) "Opioid treatment program" means as that term is defined in article five-y of chapter
116 sixteen.

117 (29) "Person" means an individual, trust, estate, partnership, limited liability corporation,
118 committee, corporation, governing body, association and other organizations such as joint-stock

119 companies and insurance companies, a state or a political subdivision or instrumentality thereof
120 or any legal entity recognized by the state.

121 (30) "Personal care agency" means an entity that provides personal care services
122 approved by the Bureau of Medical Services.

123 (31) "Personal care services" means personal hygiene; dressing; feeding; nutrition;
124 environmental support and health-related tasks provided by a personal care agency.

125 (32) "Physician" means an individual who is licensed to practice allopathic medicine by the
126 board of Medicine or licensed to practice osteopathic medicine by the board of Osteopathic
127 Medicine.

128 (33) "Proposed health service" means any service as described in section eight of this
129 article.

130 (34) "Purchaser" means an individual who is directly or indirectly responsible for payment
131 of patient care services rendered by a health care provider, but does not include third-party
132 payers.

133 (35) "Rates" means charges imposed by a health care facility for health services.

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

139 (37) "Rehabilitation facility" means an inpatient facility licensed in West Virginia operated
140 for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated
141 program of medical and other services.

142 (38) "Related organization" means an organization, whether publicly owned, nonprofit, tax-
143 exempt or for profit, related to a health care facility through common membership, governing
144 bodies, trustees, officers, stock ownership, family members, partners or limited partners,

145 including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For
146 the purposes of this subdivision “family members” means parents, children, brothers and sisters
147 whether by the whole or half blood, spouse, ancestors and lineal descendants.

148 (39) “Secretary” means the Secretary of the West Virginia Department of Health and
149 Human Resources;

150 (40) “Skilled nursing facility” means an institution, or a distinct part of an institution, that
151 primarily provides inpatient skilled nursing care and related services, or rehabilitation services, to
152 injured, disabled or sick persons.

153 (41) “Standard” means a health service guideline developed by the authority and instituted
154 under section six.

155 (42) “State health plan” means a document prepared by the authority that sets forth a
156 strategy for future health service needs in this state.

157 (43) “Substantial change to the bed capacity” of a health care facility means any change,
158 associated with a capital expenditure, that increases or decreases the bed capacity or relocates
159 beds from one physical facility or site to another, but does not include a change by which a health
160 care facility reassigns existing beds.

161 (44) “Substantial change to the health services” means:

162 (A) The addition of a health service offered by or on behalf of the health care facility which
163 was not offered by or on behalf of the facility within the twelve-month period before the month in
164 which the service was first offered; or

165 (B) The termination of a health service offered by or on behalf of the facility but does not
166 include the termination of ambulance service, wellness centers or programs, adult day care or
167 respite care by acute care facilities.

168 (45) “Telehealth” means the use of electronic information and telecommunications
169 technologies to support long-distance clinical health care, patient and professional health-related
170 education, public health and health administration.

171 (46) "Third-party payor" means an individual, person, corporation or government entity
172 responsible for payment for patient care services rendered by health care providers.

173 (47) "To develop" means to undertake those activities which upon their completion will
174 result in the offer of a proposed health service or the incurring of a financial obligation in relation
175 to the offering of such a service.

§16-2D-3. Powers and duties of the authority.

1 (a) The authority shall:

2 (1) Administer the certificate of need program;

3 (2) Review the state health plan, the certificate of need standards, and the cost
4 effectiveness of the certificate of need program and make any amendments and modifications to
5 each that it may deem necessary, no later than September 1, 2017, and biennially thereafter.

6 (3) Shall adjust the expenditure minimum annually and publish to its website the updated
7 amount on or before December 31, of each year. The expenditure minimum adjustment shall be
8 based on the DRI inflation index.

9 (4) Create a standing advisory committee to advise and assist in amending the state health
10 plan, the certificate of need standards, and performing the state agencies' responsibilities.

11 (b) The authority may:

12 (1) (A) Order a moratorium upon the offering or development of a health service when
13 criteria and guidelines for evaluating the need for the health service have not yet been adopted
14 or are obsolete or when it determines that the proliferation of the health service may cause an
15 adverse impact on the cost of health services or the health status of the public.

16 (B) A moratorium shall be declared by a written order which shall detail the circumstances
17 requiring the moratorium. Upon the adoption of criteria for evaluating the need for the health
18 service affected by the moratorium, or one hundred eighty days from the declaration of a
19 moratorium, whichever is less, the moratorium shall be declared to be over and applications for
20 certificates of need are processed pursuant to section eight.

21 (2) Approve an emerging health service or technology for one year.

22 (3) Exempt from certificate of need or annual assessment requirements to financially
23 vulnerable health care facilities located in underserved areas that the state agency and the Office
24 of Community and Rural Health Services determine are collaborating with other providers in the
25 service area to provide cost effective health services.

§16-2D-4. Rulemaking.

1 (a) The authority shall propose rules for legislative approval in accordance with the
2 provisions of article three, chapter twenty-nine-a of this code, to implement the following:

3 (1) Information a person shall provide when applying for a certificate of need;

4 (2) Information a person shall provide when applying for an exemption;

5 (3) Process for the issuance of grants and loans to financially vulnerable health care
6 facilities located in underserved areas;

7 (4) Information a person shall provide in a letter of intent;

8 (5) Process for an expedited certificate of need;

9 (6) Determine medically underserved population. The authority may consider unusual
10 local conditions that are a barrier to accessibility or availability of health services. The authority
11 may consider when making its determination of a medically underserved population designated
12 by the federal Secretary of Health and Human Services under Section 330(b)(3) of the Public
13 Health Service Act, as amended, Title 42 U.S.C. §254;

14 (7) Process to review an approved certificate of need; and

15 (8) Process to review approved proposed health services for which the expenditure
16 maximum is exceeded or is expected to be exceeded.

17 (b) All of the authority's rules in effect and not in conflict with the provisions of this article,
18 shall remain in effect until they are amended or rescinded.

§16-2D-5. Fee; special revenue account; administrative fines.

1 (a) All fees and other moneys, except administrative fines, received by the authority shall
2 be deposited in a separate special revenue fund in the State Treasury which is continued and
3 shall be known as the "Certificate of Need Program Fund". Expenditures from this fund shall be
4 for the purposes set forth in this article and are not authorized from collections but are to be made
5 only in accordance with appropriation by the Legislature and in accordance with the provisions of
6 article three, chapter twelve of this code and upon fulfillment of the provisions of article two,
7 chapter eleven-b of this code: *Provided*, That for the fiscal year ending June 30, 2017,
8 expenditures are authorized from collections rather than pursuant to appropriation by the
9 Legislature.

10 (b) Any amounts received as administrative fines imposed pursuant to this article shall be
11 deposited into the General Revenue Fund of the State Treasury.

§16-2D-8. Proposed health services that require a certificate of need.

1 (a) Except as provided in sections nine, ten and eleven of this article, the following
2 proposed health services may not be acquired, offered or developed within this state except upon
3 approval of and receipt of a certificate of need as provided by this article:

4 (1) The construction, development, acquisition or other establishment of a health care
5 facility;

6 (2) The partial or total closure of a health care facility with which a capital expenditure is
7 associated;

8 (3) (A) An obligation for a capital expenditure incurred by or on behalf of a health care
9 facility, in excess of the expenditure minimum; or

10 (B) An obligation for a capital expenditure incurred by a person to acquire a health care
11 facility.

12 (4) An obligation for a capital expenditure is considered to be incurred by or on behalf of
13 a health care facility:

14 (A) When a valid contract is entered into by or on behalf of the health care facility for the
15 construction, acquisition, lease or financing of a capital asset;

16 (B) When the health care facility takes formal action to commit its own funds for a
17 construction project undertaken by the health care facility as its own contractor; or

18 (C) In the case of donated property, on the date on which the gift is completed under state
19 law.

20 (5) A substantial change to the bed capacity of a health care facility with which a capital
21 expenditure is associated;

22 (6) The addition of ventilator services by a hospital;

23 (7) The elimination of health services previously offered on a regular basis by or on behalf
24 of a health care facility which is associated with a capital expenditure;

25 (8) (A) A substantial change to the bed capacity or health services offered by or on behalf
26 of a health care facility, whether or not the change is associated with a proposed capital
27 expenditure;

28 (B) If the change is associated with a previous capital expenditure for which a certificate
29 of need was issued; and

30 (C) If the change will occur within two years after the date the activity which was associated
31 with the previously approved capital expenditure was undertaken.

32 (9) The acquisition of major medical equipment;

33 (10) A substantial change in an approved health service for which a certificate of need is
34 in effect;

35 (11) An expansion of the service area for hospice or home health agency regardless of
36 the time period in which the expansion is contemplated or made; and

37 (12) The addition of health services offered by or on behalf of a health care facility which
38 were not offered on a regular basis by or on behalf of the health care facility within the twelve-
39 month period prior to the time the services would be offered.

40 (b) The following health services are required to obtain a certificate of need regardless of
41 the minimum expenditure:

- 42 (1) Constructing, developing, acquiring or establishing of a birthing center;
- 43 (2) Providing radiation therapy;
- 44 (3) Providing computed tomography;
- 45 (4) Providing positron emission tomography;
- 46 (5) Providing cardiac surgery;
- 47 (6) Providing fixed magnetic resonance imaging;
- 48 (7) Providing comprehensive medical rehabilitation;
- 49 (8) Establishing an ambulatory care center;
- 50 (9) Establishing an ambulatory surgical center;
- 51 (10) Providing diagnostic imaging;
- 52 (11) Providing cardiac catheterization services;
- 53 (12) Constructing, developing, acquiring or establishing of kidney disease treatment
54 centers, including freestanding hemodialysis units;
- 55 (13) Providing megavoltage radiation therapy;
- 56 (14) Providing surgical services;
- 57 (15) Establishing operating rooms;
- 58 (16) Adding acute care beds;
- 59 (17) Providing intellectual developmental disabilities services;
- 60 (18) Providing organ and tissue transplants;
- 61 (19) Establishing an intermediate care facility for individuals with intellectual disabilities;
- 62 (20) Providing inpatient services;
- 63 (21) Providing hospice services;
- 64 (22) Establishing a home health agency; and
- 65 (23) Providing personal care services.

66 (c) A certificate of need previously approved under this article remains in effect unless
67 revoked by the authority.

§16-2D-9. Health services that cannot be developed.

1 Notwithstanding section eight and eleven, these health services require a certificate of
2 need but the authority may not issue a certificate of need to:

3 (1) A health care facility adding intermediate care or skilled nursing beds to its current
4 licensed bed complement, except as provided in subdivision twenty-three, subsection (c), section
5 eleven;

6 (2) A person developing, constructing or replacing a skilled nursing facility except in the
7 case of facilities designed to replace existing beds in existing facilities that may soon be deemed
8 unsafe or facilities utilizing existing licensed beds from existing facilities which are designed to
9 meet the changing health care delivery system;

10 (3) Add beds in an intermediate care facility for individuals with an intellectual disability,
11 except that prohibition does not apply to an intermediate care facility for individuals with
12 intellectual disabilities beds approved under the Kanawha County circuit court order of August 3,
13 1989, civil action number MISC-81-585 issued in the case of E.H. v. Matin, 168 W.V. 248, 284
14 S.E. 2d 232 (1981); and

15 (4) An opioid treatment program.

§16-2D-10. Exemptions from certificate of need.

1 Notwithstanding section eight, a person may provide the following health services without
2 obtaining a certificate of need or applying to the authority for approval:

3 (1) The creation of a private office of one or more licensed health professionals to practice
4 in this state pursuant to chapter thirty of this code;

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

8 (3) A place that provides remedial care or treatment of residents or patients conducted
9 only for those who rely solely upon treatment by prayer or spiritual means in accordance with the
10 creed or tenets of any recognized church or religious denomination;

11 (4) Telehealth;

12 (5) A facility owned or operated by one or more health professionals authorized or
13 organized pursuant to chapter thirty or ambulatory health care facility which offers laboratory
14 services or diagnostic imaging to patients regardless of the cost associated with the proposal. To
15 qualify for this exemption seventy-five percent of the laboratory services are for the patients of
16 the practice or ambulatory health care facility of the total laboratory services performed and
17 seventy-five percent of diagnostic imaging services are for the patients of the practice or
18 ambulatory health care facility of the total imaging services performed. The authority may, at any
19 time, request from the entity information concerning the number of patients who have been
20 provided laboratory services or diagnostic imaging;

21 (6) (A) Notwithstanding the provisions of section seventeen of this article, any hospital
22 that holds a valid certificate of need issued pursuant to this article, may transfer that certificate of
23 need to a person purchasing that hospital, or all or substantially all of its assets, if the hospital is
24 financially distressed. A hospital is financially distressed if, at the time of its purchase:

25 (i) It has filed a petition for voluntary bankruptcy;

26 (ii) It has been the subject of an involuntary petition for bankruptcy;

27 (iii) It is in receivership;

28 (iv) It is operating under a forbearance agreement with one or more of its major creditors;

29 (v) It is in default of its obligations to pay one or more of its major creditors and is in
30 violation of the material, substantive terms of its debt instruments with one or more of its major
31 creditors; or

32 (vi) It is insolvent: evidenced by balance sheet insolvency and/or the inability to pay its
33 debts as they come due in the ordinary course of business.

34 (B) A financially distressed hospital which is being purchased pursuant to the provisions
35 of this subsection shall give notice to the authority of the sale thirty days prior to the closing of the
36 transaction and shall file simultaneous with that notice evidence of its financial status. The
37 financial status or distressed condition of a hospital shall be evidenced by the filing of any of the
38 following:

39 (i) A copy of a forbearance agreement;

40 (ii) A copy of a petition for voluntary or involuntary bankruptcy;

41 (iii) Written evidence of receivership, or

42 (iv) Documentation establishing the requirements of subparagraph (v) or (vi), paragraph
43 (A) of this subdivision. The names of creditors may be redacted by the filing party.

44 (C) Any substantial change to the capacity of services offered in that hospital made
45 subsequent to that transaction would remain subject to the requirements for the issuance of a
46 certificate of need as otherwise set forth in this article.

47 (D) Any person purchasing a financially distressed hospital, or all or substantially all of its
48 assets, that has applied for a certificate of need after January 1, 2017, shall qualify for an
49 exemption from certificate of need;

50 (7) The acquisition by a qualified hospital which is party to an approved cooperative
51 agreement as provided in section twenty-eight, article twenty-nine-b, chapter sixteen of this code,
52 of a hospital located within a distance of twenty highway miles of the main campus of the qualified
53 hospital; and

54 (8) The acquisition by a hospital of a physician practice group which owns an ambulatory
55 surgical center as defined in this article.

§16-2D-11. Exemptions from certificate of need which require approval from the authority.

1 (a) To obtain an exemption under this section a person shall:

2 (1) File an exemption application;

3 (2) Pay the \$1,000 application fee; and

4 (3) Provide a statement detailing which exemption applies and the circumstances justifying
5 the approval of the exemption.

6 (b) The authority has forty-five days to review the exemption request. The authority may
7 not hold an administrative hearing to review the application. A person may not file an objection
8 to the request for an exemption. The applicant may request or agree with the authority to a fifteen
9 day extension of the timeframe. If the authority does not approve or deny the application within
10 forty-five days, then the exemption is immediately approved. If the authority denies the approval
11 of the exemption, only the applicant may appeal the authority's decision to the Office of Judges
12 or refile the application with the authority.

13 (c) Notwithstanding section eight and ten and except as provided in section nine of this
14 article, the Legislature finds that a need exists and these health services are exempt from the
15 certificate of need process:

16 (1) The acquisition and utilization of one computed tomography scanner with a purchase
17 price up to \$750,000 that is installed in a private office practice where at minimum seventy-five
18 percent of the scans are performed on the patients of the practice. The private office practice
19 shall obtain and maintain accreditation from the American College of Radiology prior to, and at all
20 times during, the offering of this service. The authority may at any time request from the private
21 office practice information relating to the number of patients who have been provided scans and
22 proof of active and continuous accreditation from the American College of Radiology. If a
23 physician owns or operates a private office practice in more than one location, this exemption
24 shall only apply to the physician's primary place of business and if a physician wants to expand
25 the offering of this service to include more than one computed topography scanner, he or she
26 shall be required to obtain a certificate of need prior to expanding this service. All current
27 certificates of need issued for computed tomography services, with a required percentage
28 threshold of scans to be performed on patients of the practice in excess of seventy-five percent,
29 shall be reduced to seventy-five percent: *Provided*, That these limitations on the exemption for a

30 private office practice with more than one location shall not apply to a private office practice with
31 more than twenty locations in the state at the time of the changes made to this article during the
32 2017 Regular Session of the Legislature.

33 (2) (A) A birthing center established by a nonprofit primary care center that has a
34 community board and provides primary care services to people in their community without regard
35 to ability to pay; or

36 (B) A birthing center established by a nonprofit hospital with less than one hundred
37 licensed acute care beds.

38 (i) To qualify for this exemption, an applicant shall be located in an area that is underserved
39 with respect to low-risk obstetrical services; and

40 (ii) Provide a proposed health service area.

41 (3) (A) A health care facility acquiring major medical equipment, adding health services or
42 obligating a capital expenditure to be used solely for research;

43 (B) To qualify for this exemption, the health care facility shall show that the acquisition,
44 offering or obligation will not:

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

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

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

49 (C) For purposes of this subdivision, the term “solely for research” includes patient care
50 provided on an occasional and irregular basis and not as part of a research program;

51 (4) The obligation of a capital expenditure to acquire, either by purchase, lease or
52 comparable arrangement, the real property, equipment or operations of a skilled nursing facility:

53 *Provided*, That a skilled nursing facility developed pursuant to subdivision (17) of this section and
54 subsequently acquired pursuant to this subdivision may not transfer or sell any of the skilled

55 nursing home beds of the acquired skilled nursing facility until the skilled nursing facility has been
56 in operation for at least ten years.

57 (5) Shared health services between two or more hospitals licensed in West Virginia
58 providing health services made available through existing technology that can reasonably be
59 mobile. This exemption does not include providing mobile cardiac catheterization;

60 (6) The acquisition, development or establishment of a certified interoperable electronic
61 health record or electronic medical record system;

62 (7) The addition of forensic beds in a health care facility;

63 (8) A behavioral health service selected by the Department of Health and Human
64 Resources in response to its request for application for services intended to return children
65 currently placed in out-of-state facilities to the state or to prevent placement of children in out-of-
66 state facilities is not subject to a certificate of need;

67 (9) The replacement of major medical equipment with like equipment, only if the
68 replacement major medical equipment cost is more than the expenditure minimum;

69 (10) Renovations within a hospital, only if the renovation cost is more than the expenditure
70 minimum. The renovations may not expand the health care facility's current square footage, incur
71 a substantial change to the health services, or a substantial change to the bed capacity;

72 (11) Renovations to a skilled nursing facility;

73 (12) The construction, development, acquisition or other establishment by a hospital of an
74 ambulatory health care facility in the county in which it is located;

75 (13) The donation of major medical equipment to replace like equipment for which a
76 certificate of need has been issued and the replacement does not result in a substantial change
77 to health services. This exemption does not include the donation of major medical equipment
78 made to a health care facility by a related organization;

79 (14) A person providing specialized foster care personal care services to one individual
80 and those services are delivered in the provider's home;

81 (15) A hospital converting the use of beds except a hospital may not convert a bed to a
82 skilled nursing home bed and conversion of beds may not result in a substantial change to health
83 services provided by the hospital;

84 (16) The construction, renovation, maintenance or operation of a state owned veterans
85 skilled nursing facilities established pursuant to the provisions of article one-b of this chapter;

86 (17) To develop and operate a skilled nursing facility with no more than thirty-six beds in
87 a county that currently is without a skilled nursing facility;

88 (18) A critical access hospital, designated by the state as a critical access hospital, after
89 meeting all federal eligibility criteria, previously licensed as a hospital and subsequently closed, if
90 it reopens within ten years of its closure;

91 (19) The establishing of a health care facility or offering of health services for children under
92 one year of age suffering from Neonatal Abstinence Syndrome;

93 (20) The construction, development, acquisition or other establishment of community
94 mental health and intellectual disability facility;

95 (21) Providing behavioral health facilities and services;

96 (22) The construction, development, acquisition or other establishment of kidney disease
97 treatment centers, including freestanding hemodialysis units but only to a medically underserved
98 population;

99 (23) The transfer, purchase or sale of intermediate care or skilled nursing beds from a
100 skilled nursing facility or a skilled nursing unit of an acute care hospital to a skilled nursing facility
101 providing intermediate care and skilled nursing services. No state agency may deny payment to
102 an acquiring nursing home or place any restrictions on the beds transferred under this subsection.
103 The transferred beds shall retain the same certification status that existed at the nursing home or
104 hospital skilled nursing unit from which they were acquired. If construction is required to place
105 the transferred beds into the acquiring nursing home, the acquiring nursing home has one year
106 from the date of purchase to commence construction;

107 (24) The construction, development, acquisition or other establishment by a health care
108 facility of a nonhealth related project, only if the nonhealth related project cost is more than the
109 expenditure minimum;

110 (25) The construction, development, acquisition or other establishment of an alcohol or
111 drug treatment facility and drug and alcohol treatment services unless the construction,
112 development, acquisition or other establishment is an opioid treatment facility or programs as set
113 forth in subdivision (4) of section nine of this article;

114 (26) Assisted living facilities and services; and

115 (27) The creation, construction, acquisition or expansion of a community-based nonprofit
116 organization with a community board that provides or will provide primary care services to people
117 without regard to ability to pay and receives approval from the Health Resources and Services
118 Administration.

§16-2D-13. Procedures for certificate of need reviews.

1 (a) An application for a certificate of need shall be submitted to the authority prior to the
2 offering or developing of a proposed health service.

3 (b) A person proposing a proposed health service shall:

4 (1) Submit a letter of intent ten days prior to submitting the certificate of need application.
5 If the tenth day falls on a weekend or holiday, the certificate of need application shall be filed on
6 the next business day. The information required within the letter of intent shall be detailed by the
7 authority in legislative rule;

8 (2) Submit the appropriate application fee;

9 (A) Up to \$1,500,000 a fee of \$1,500.00;

10 (B) From \$1,500,001 to \$5,000,000 a fee of \$5,000.00;

11 (C) From \$5,000,001 to \$25,000,000 a fee of \$25,000.00; and

12 (D) From \$25,000,001 and above a fee of \$35,000.00.

13 (3) Submit to the Director of the Office of Insurance Consumer Advocacy a copy of the
14 application;

15 (c) The authority shall determine if the submitted application is complete within ten days
16 of receipt of the application. The authority shall provide written notification to the applicant of this
17 determination. If the authority determines an application to be incomplete, the authority may
18 request additional information from the applicant.

19 (d) Within five days of receipt of a letter of intent, the authority shall provide notification to
20 the public through a newspaper of general circulation in the area where the health service is being
21 proposed and by placing of copy of the letter of intent on its website. The newspaper notice shall
22 contain a statement that, further information regarding the application is on the authority's web
23 site.

24 (e) The authority may batch completed applications for review on the fifteenth day of the
25 month or the last day of month in which the application is deemed complete.

26 (f) When the application is submitted, ten days after filing the letter of intent, the application
27 shall be placed on the authority's website.

28 (g) An affected party has thirty days starting from the date the application is batched to
29 request the authority hold an administrative hearing.

30 (1) A hearing order shall be approved by the authority within fifteen days from the last day
31 an affected person may requests an administrative hearing on a certificate of need application.

32 (2) A hearing shall take place no later than three months from that date the hearing order
33 was approved by the authority.

34 (3) The authority shall conduct the administrative hearing in accordance with
35 administrative hearing requirements in section twelve, article twenty-nine-b of this chapter and
36 article five, chapter twenty-nine-a of this code.

37 (4) In the administrative hearing an affected person has the right to be represented by
38 counsel and to present oral or written arguments and evidence relevant to the matter which is the

39 subject of the public hearing. An affected person may conduct reasonable questioning of persons
40 who make factual allegations relevant to its certificate of need application.

41 (5) The authority shall maintain a verbatim record of the administrative hearing.

42 (6) After the commencement of the administrative hearing on the application and before a
43 decision is made with respect to it, there may be no ex parte contacts between:

44 (A) The applicant for the certificate of need, any person acting on behalf of the applicant
45 or holder of a certificate of need or any person opposed to the issuance of a certificate for the
46 applicant; and

47 (B) Any person in the authority who exercises any responsibility respecting the application.

48 (7) The authority may not impose fees to hold the administrative hearing.

49 (8) The authority shall render a decision within forty-five days of the conclusion of the
50 administrative hearing.

51 (h) If an administrative hearing is not conducted during the review of an application, the
52 authority shall provide a file closing date five days after an affected party may no longer request
53 an administrative hearing, after which date no other factual information or evidence may be
54 considered in the determination of the application for the certificate of need. A detailed itemization
55 of documents in the authority's file on a proposed health service shall, on request, be made
56 available by the authority at any time before the file closing date.

57 (i) The extent of additional information received by the authority from the applicant for a
58 certificate of need after a review has begun on the applicant's proposed health service, with
59 respect to the impact on the proposed health service and additional information which is received
60 by the authority from the applicant, may be cause for the authority to determine the application to
61 be a new proposal, subject to a new review cycle.

62 (j) The authority shall have five days to provide the written status update upon written
63 request by the applicant or an affected person. The status update shall include the findings made
64 in the course of the review and any other appropriate information relating to the review.

65 (k) (1) The authority shall annually prepare and publish to its website, a status report of
66 each ongoing and completed certificate of need application reviews.

67 (2) For a status report of an ongoing review, the authority shall include in its report all
68 findings made during the course of the review and any other appropriate information relating to
69 the review.

70 (3) For a status report of a completed review, the authority shall include in its report all the
71 findings made during the course of the review and its detailed reasoning for its final decision.

72 (l) The authority shall provide for access by the public to all applications reviewed by the
73 authority and to all other pertinent written materials essential to agency review.

**§16-2D-15. Authority to render final decision; issue certificate of need; write findings;
specify capital expenditure maximum.**

1 (a) The authority shall render a final decision on an application for a certificate of need in
2 the form of an approval, a denial or an approval with conditions. The final decision with respect
3 to a certificate of need shall be based solely on:

4 (1) The authority's review conducted in accordance with procedures and criteria in this
5 article and the certificate of need standards; and

6 (2) The record established in the administrative hearing held with respect to the certificate
7 of need.

8 (b) Approval with conditions does not give the authority the ability to mandate a health
9 service not proposed by the health care facility. Issuance of a certificate of need or exemption
10 may not be made subject to any condition unless the condition directly relates to criteria in this
11 article, or in the certificate of need standards. Conditions may be imposed upon the operations
12 of the health care facility for not longer than a three-year period.

13 (c) The authority shall send its decision along with written findings to the person proposing
14 the proposed health service or exemption and shall make it available to others upon request.

15 (d) In the case of a final decision to approve or approve with conditions a proposal for a
16 proposed health service, the authority shall issue a certificate of need to the person proposing the
17 proposed health service.

18 (e) The authority shall specify in the certificate of need the maximum amount of capital
19 expenditures which may be obligated. The authority shall adopt legislative rules pursuant to
20 section four to prescribe the method used to determine capital expenditure maximums and a
21 process to review the implementation of an approved certificate of need for a proposed health
22 service for which the capital expenditure maximum is exceeded or is expected to be exceeded.

§16-2D-16. Appeal of certificate of need a decision.

1 (a) An applicant or an affected person may appeal the authority's final decision in a
2 certificate of need review to the Office of Judges. The request shall be received within thirty days
3 after the date of the authority's decision. The appeal hearing shall commence within thirty days
4 of receipt of the request.

5 (b) The Office of Judges shall conduct its proceedings in conformance with the West
6 Virginia Rules of Civil Procedure for trial courts of record and the local rules for use in the civil
7 courts of Kanawha County and shall review appeals in accordance with the provisions governing
8 the judicial review of contested administrative cases in article five, chapter twenty-nine-a of this
9 code.

10 (c) The decision of the Office of Judges shall be made in writing within forty-five days after
11 the conclusion of the hearing.

12 (d) The written findings of the Office of Judges shall be sent to the person who requested
13 the appeal, to the person proposing the proposed health service and to the authority, and shall
14 be made available by the authority to others upon request.

15 (e) The decision of the Office of Judges shall be considered the final decision of the
16 authority; however, the Office of Judges may remand the matter to the authority for further action
17 or consideration.

18 (f) Upon the entry of a final decision by the Office of Judges, an affected person may within
19 thirty days after the date of the decision of the Office of Judges make an appeal in the circuit court
20 of Kanawha County. The decision of the Office of Judges shall be reviewed by the circuit court in
21 accordance with the provisions for the judicial review of administrative decisions contained in
22 article five, chapter twenty-nine-a of this code.

ARTICLE 5B. HOSPITALS AND SIMILAR INSTITUTIONS.

§16-5B-17. Healthcare-associated infection reporting.

1 (a) As used in this section, the following words mean:

2 (1) "Centers for Disease Control and Prevention" or "CDC" means the United States
3 Department of Health and Human Services Centers for Disease Control and Prevention;

4 (2) "National Healthcare Safety Network" or "NHSN" means the secure Internet-based
5 data collection surveillance system managed by the Division of Healthcare Quality Promotion at
6 the CDC, created by the CDC for accumulating, exchanging and integrating relevant information
7 on infectious adverse events associated with healthcare delivery.

8 (3) "Hospital" means hospital as that term is defined in subsection-e, section three, article
9 twenty-nine-b, chapter sixteen.

10 (4) "Healthcare-associated infection" means a localized or systemic condition that results
11 from an adverse reaction to the presence of an infectious agent or a toxin of an infectious agent
12 that was not present or incubating at the time of admission to a hospital.

13 (5) "Physician" means a person licensed to practice medicine by either the board of
14 Medicine or the board of osteopathy.

15 (6) "Nurse" means a person licensed in West Virginia as a registered professional nurse
16 in accordance with article seven, chapter thirty.

17 (b) The Secretary of the Department of Health and Human Resources is hereby directed
18 to create an Infection Control Advisory Panel whose duty is to provide guidance and oversight in
19 implementing this section. The advisory panel shall consist of the following members:

20 (1) Two board-certified or board-eligible physicians, affiliated with a West Virginia hospital
21 or medical school, who are active members of the Society for Health Care Epidemiology of
22 America and who have demonstrated an interest in infection control;

23 (2) One physician who maintains active privileges to practice in at least one West Virginia
24 hospital;

25 (3) Three infection control practitioners, two of whom are nurses, each certified by the
26 Certification Board of Infection Control and Epidemiology, and each working in the area of
27 infection control. Rural and urban practice must be represented;

28 (4) A statistician with an advanced degree in medical statistics;

29 (5) A microbiologist with an advanced degree in clinical microbiology;

30 (6) The Director of the Division of Disease Surveillance and Disease Control in the Bureau
31 for Public Health or a designee; and

32 (7) The director of the hospital program in the office of health facilities, licensure and
33 certification in the Bureau for Public Health.

34 (c) The advisory panel shall:

35 (1) Provide guidance to hospitals in their collection of healthcare-associated infections;

36 (2) Provide evidence-based practices in the control and prevention of healthcare
37 associated infections;

38 (3) Establish reasonable goals to reduce the number of healthcare-associated infections;

39 (4) Develop plans for analyzing infection-related data from hospitals;

40 (5) Develop healthcare-associated advisories for hospital distribution;

41 (6) Review and recommend to the Secretary of the Department of Health and Human
42 Resources the manner in which the reporting is made available to the public to assure that the
43 public understands the meaning of the report; and

44 (7) Other duties as identified by the Secretary of the Department of Health and Human
45 Resources.

46 (d) Hospitals shall report information on healthcare-associated infections in the manner
47 prescribed by the CDC National Healthcare Safety Network(NHSN). The reporting standard
48 prescribed by the CDC National Healthcare Safety Network(NHSN) shall be the reporting system
49 of the hospitals in West Virginia.

50 (e) Hospitals who fail to report information on healthcare associated infections in the
51 manner and time frame required by the Secretary of the Department of Health and Human
52 Resources shall be fined the sum of \$5,000 for each such failure.

53 (f) The Infection Control Advisory Panel shall provide the results of the collection and
54 analysis of all hospital data to the Secretary of the Department of Health and Human Resources
55 for public availability and the Bureau for Public Health for consideration in their hospital oversight
56 and epidemiology and disease surveillance responsibilities in West Virginia.

57 (g) Data collected and reported pursuant to this act may not be considered to establish
58 standards of care for any purposes of civil litigation in West Virginia.

59 (h) The Secretary of the Department of Health and Human Resources shall require that
60 all hospitals implement and initiate this reporting requirement.

ARTICLE 29B. HEALTH CARE AUTHORITY.

§16-29B-2. Effective Date.

1 Effective the first day of July, 2017, all powers, duties and functions of the West Virginia
2 Health Care Authority shall be transferred to the West Virginia Department of Health and Human
3 Resources.

§16-29B-3. Definitions.

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

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

4 (a) "Authority" means the Health Care Authority created pursuant to the provisions of this
5 article;

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

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

10 (d) "Class of purchaser" means a group of potential hospital patients with common
11 characteristics affecting the way in which their hospital care is financed. Examples of classes of
12 purchasers are Medicare beneficiaries, welfare recipients, subscribers of
13 corporations established and operated pursuant to article twenty-four, chapter thirty-three of this
14 code, members of health maintenance organizations and other groups as defined by the authority;

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

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

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

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

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

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

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

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

47 (m) "Secretary" means the Secretary of the Department of Health and Human Resources;
48 and

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

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

1 (a) The "West Virginia Health Care Authority" is continued as a division of the Department
2 of Health and Human Resources. Any references in this code to the West Virginia Health Care
3 Cost Review Authority means the West Virginia Health Care Authority.

4 (b) There is created a board of review to serve as the adjudicatory body of the authority
5 and shall conduct all hearings as required in this article, article two-d of this chapter.

6 (1) The board shall consist of five members, appointed by the Governor, with the advice
7 and consent of the Senate. The board members are not permitted to hold political office in the
8 government of the state either by election or appointment while serving as a member of the board.
9 The board members are not eligible for civil service coverage as provided in section four, article
10 six, chapter twenty-nine of this code. The board members shall be citizens and residents of this
11 state.

12 (2) No more than three of the board members may be members of the same political party.
13 One board member shall have a background in health care finance or economics, one board
14 member shall have previous employment experience in human services, business administration
15 or substantially related fields, one board member shall have previous experience in the
16 administration of a health care facility, one board member shall have previous experience as a
17 provider of health care services, and one board member shall be a consumer of health services
18 with a demonstrated interest in health care issues.

19 (3) Each member appointed by the Governor shall serve staggered terms of six years.
20 Any member whose term has expired shall serve until his or her successor has been appointed.
21 Any person appointed to fill a vacancy shall serve only for the unexpired term. Any member shall
22 be eligible for reappointment. In cases of vacancy in the office of member, such vacancy shall be
23 filled by the Governor in the same manner as the original appointment.

24 (4) Each board member shall, before entering upon the duties of his or her office, take and
25 subscribe to the oath provided by section five, article IV of the Constitution of the State of West
26 Virginia, which oath shall be filed in the office of the Secretary of State.

27 (5) The Governor shall designate one of the board members to serve as chairman at the
28 Governor's will and pleasure.

29 (6) The Governor may remove any board member only for incompetency, neglect of duty,
30 gross immorality, malfeasance in office or violation of the provisions of this article.

31 (7) No person while in the employ of, or holding any official relation to, any hospital or
32 health care provider subject to the provisions of this article, or who has any pecuniary interest in
33 any hospital or health care provider, may serve as a member of the board. Nor may any board
34 member be a candidate for or hold public office or be a member of any political committee while
35 acting as a board member; nor may any board member or employee of the board receive anything
36 of value, either directly or indirectly, from any third-party payor or health care provider. If any of
37 the board members become a candidate for any public office or for membership on any political
38 committee, the Governor shall remove the board member from the board and shall appoint a new
39 board member to fill the vacancy created. No board member or former board member may accept
40 employment with any hospital or health care provider subject to the jurisdiction of the board in
41 violation of the West Virginia governmental ethics act, chapter six-b of this code: *Provided, That*
42 the act may not apply to employment accepted after termination of the board.

43 (8) The concurrent judgment of three of the board members shall be considered the action
44 of the board. A vacancy in the board does not affect the right or duty of the remaining board
45 members to function as a board.

46 (9) Each member of the board shall serve without compensation, but shall receive
47 expense reimbursement for all reasonable and necessary expenses actually incurred in the
48 performance of the duties of the office, in the same amount paid to members of the Legislature
49 for their interim duties as recommended by the citizens legislative compensation commission and
50 authorized by law. No member may be reimbursed for expenses paid by a third party.

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

1 (a) The Secretary shall appoint an executive director of the authority to supervise and
2 direct the fiscal and administrative matters of the authority. This person shall be qualified by
3 training and experience to direct the operations of the authority. The executive director is ineligible

4 for civil service coverage as provided in section four, article six, chapter twenty-nine of this code
5 and serves at the will and pleasure of the Secretary.

6 (b) The executive director shall:

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

9 (2) Not hold political office in the government of the state either by election or appointment
10 while serving as executive director;

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

13 (4) Report to the Secretary.

14 (c) The executive director has other powers and duties as set forth in this article.

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

1 In addition to the powers granted to the authority elsewhere in this article, the authority
2 may:

3 (1) Adopt, amend and repeal necessary, appropriate and lawful policy guidelines, and in
4 cooperation with the Secretary, propose rules in accordance with article three, chapter twenty-
5 nine-a of this code;

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

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

**§16-29B-12. Certificate of need hearings; administrative procedures act applicable;
hearings examiner; subpoenas.**

1 (a) The board shall conduct such hearings as it deems necessary for the performance of
2 its functions and shall hold hearings when required by the provisions of this chapter or upon a
3 written demand by a person aggrieved by any act or failure to act by the board regulation or order
4 of the board. All hearings of the board pursuant to this section shall be announced in a timely
5 manner and shall be open to the public. In making decisions in the certificate of need process,
6 the board shall be guided by the state health plan approved by the Governor.

7 (b) All pertinent provisions of article five, chapter twenty-nine-a of this code shall apply to
8 and govern the hearing and administrative procedures in connection with and following the
9 hearing except as specifically stated to the contrary in this article. General counsel for Department
10 of Health and Human Resources or general counsel for the authority shall represent the interest
11 of the authority at all hearings.

12 (c) Any hearing may be conducted by members of the board or by a hearing examiner
13 appointed by the board for such purpose. The chairperson of the board may issue subpoenas
14 and subpoenas duces tecum which shall be issued and served pursuant to the time, fee and
15 enforcement specifications in section one, article five, chapter twenty-nine-a of this code.

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

20 (e) After any hearing, after due deliberation, and in consideration of all the testimony, the
21 evidence and the total record made, the board shall render a decision in writing. The written
22 decision shall be accompanied by findings of fact and conclusions of law as specified in section
23 three, article five, chapter twenty-nine-a of this code, and the copy of the decision and
24 accompanying findings and conclusions shall be served by certified mail, return receipt requested,
25 upon the party demanding the hearing, and upon its attorney of record, if any.

26 (f) Any interested individual, group or organization shall be recognized as affected parties
27 upon written request from the individual, group or organization. Affected parties shall have the
28 right to bring relevant evidence before the board and testify thereon. Affected parties shall have
29 equal access to records, testimony and evidence before the board and shall have equal access
30 to the expertise of the authority's staff. The authority, with the approval of the secretary, shall have
31 authority to propose rules to administer provisions of this section.

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

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

1 (a) Actions of the authority shall be exempt from antitrust action under state and federal
2 antitrust laws. Any actions of hospitals and health care providers under the authority's jurisdiction,
3 when made in compliance with orders, directives, rules, approvals or regulations issued or
4 promulgated by the authority, shall likewise be exempt.

5 (b) It is the intention of the Legislature that this chapter shall also immunize cooperative
6 agreements approved and subject to supervision by the authority and activities conducted
7 pursuant thereto from challenge or scrutiny under both state and federal antitrust law: *Provided*,
8 That a cooperative agreement that is not approved and subject to supervision by the authority
9 shall not have such immunity.

§16-29B-28. Review of Cooperative agreements.

1 (a) *Definitions.* — As used in this section the following terms have the following meanings:

2 (1) "Academic medical center" means an accredited medical school, one or more faculty
3 practice plans affiliated with the medical school or one or more affiliated hospitals which meet the
4 requirements set forth in 42 C. F. R. 411.355(e).

5 (2) "Accredited academic hospital" means a hospital or health system that sponsor four or
6 more approved medical education programs.

7 (3) “Cooperative agreement” means an agreement between a qualified hospital which is
8 a member of an academic medical center and one or more other hospitals or other health care
9 providers. The agreement shall provide for the sharing, allocation, consolidation by merger or
10 other combination of assets, or referral of patients, personnel, instructional programs, support
11 services and facilities or medical, diagnostic, or laboratory facilities or procedures or other
12 services traditionally offered by hospitals or other health care providers.

13 (4) “Commercial health plan” means a plan offered by any third party payor that negotiates
14 with a party to a cooperative agreement with respect to patient care services rendered by health
15 care providers.

16 (5) “Health care provider” means the same as that term is defined in section three of this
17 article.

18 (6) “Teaching hospital” means a hospital or medical center that provides clinical education
19 and training to future and current health professionals whose main building or campus is located
20 in the same county as the main campus of a medical school operated by a state university.

21 (7) “Qualified hospital” means an academic medical center or teaching accredited
22 academic hospital, which has entered into a cooperative agreement with one or more hospitals
23 or other health care providers but is not a critical access hospital for purposes of this section.

24 (b) *Findings.* —

25 (1) The Legislature finds that the state’s schools of medicine, affiliated universities and
26 teaching hospitals are critically important in the training of physicians and other healthcare
27 providers who practice health care in this state. They provide access to healthcare and enhance
28 quality healthcare for the citizens of this state.

29 (2) A medical education is enhanced when medical students, residents and fellows have
30 access to modern facilities, state of the art equipment and a full range of clinical services and that,
31 in many instances, the accessibility to facilities, equipment and clinical services can be achieved

32 more economically and efficiently through a cooperative agreement among a qualified hospital
33 and one or more hospitals or other health care providers.

34 (c) *Legislative purpose.* — The Legislature encourages cooperative agreements if the
35 likely benefits of such agreements outweigh any disadvantages attributable to a reduction in
36 competition. When a cooperative agreement, and the planning and negotiations of cooperative
37 agreements, might be anticompetitive within the meaning and intent of state and federal antitrust
38 laws the Legislature believes it is in the state's best interest to supplant such laws with regulatory
39 approval and oversight by the Health Care Authority as set out in this article. The authority has
40 the power to review, approve or deny cooperative agreements, ascertain that they are beneficial
41 to citizens of the state and to medical education, to ensure compliance with the provisions of the
42 cooperative agreements relative to the commitments made by the qualified hospital and
43 conditions imposed by the Health Care Authority.

44 (d) *Cooperative Agreements.* —

45 (1) A qualified hospital may negotiate and enter into a cooperative agreement with other
46 hospitals or health care providers in the state:

47 (A) In order to enhance or preserve medical education opportunities through collaborative
48 efforts and to ensure and maintain the economic viability of medical education in this state and to
49 achieve the goals hereinafter set forth; and

50 (B) When the likely benefits outweigh any disadvantages attributable to a reduction in
51 competition that may result from the proposed cooperative agreement.

52 (2) The goal of any cooperative agreement would be to:

53 (A) Improve access to care;

54 (B) Advance health status;

55 (C) Target regional health issues;

56 (D) Promote technological advancement;

57 (E) Ensure accountability of the cost of care;

- 58 (F) Enhance academic engagement in regional health;
- 59 (G) Preserve and improve medical education opportunities;
- 60 (H) Strengthen the workforce for health-related careers; and
- 61 (I) Improve health entity collaboration and regional integration, where appropriate.

62 (3) A qualified hospital located in this state may submit an application for approval of a
63 proposed cooperative agreement to the authority. The application shall state in detail the nature
64 of the proposed arrangement including the goals and methods for achieving:

- 65 (A) Population health improvement;
- 66 (B) Improved access to health care services;
- 67 (C) Improved quality;
- 68 (D) Cost efficiencies;
- 69 (E) Ensuring affordability of care;
- 70 (F) Enhancing and preserving medical education programs; and
- 71 (G) Supporting the authority's goals and strategic mission, as applicable.

72 (4) (A) An application for review of a cooperative agreement as provided in this section
73 shall be submitted and approved prior to the finalization of the cooperative agreement, if the
74 cooperative agreement involves the merger, consolidation or acquisition of a hospital located
75 within a distance of twenty highway miles of the main campus of the qualified hospital.

76 (B) In reviewing an application for cooperative agreement, the authority shall give
77 deference to the policy statements of the Federal Trade Commission.

78 (C) If an application for a review of a cooperative agreement is not required the qualified
79 hospital may apply to the authority for approval of the cooperative agreement either before or
80 after the finalization of the cooperative agreement.

81 (e) *Procedure for review of cooperative agreements.* —

82 (1) Upon receipt of an application, the authority shall determine whether the application is
83 complete. If the authority determines the application is incomplete, it shall notify the applicant in

84 writing of additional items required to complete the application. A copy of the complete application
85 shall be provided by the parties to the Office of the Attorney General simultaneous with the
86 submission to the authority. If an applicant believes the materials submitted contain proprietary
87 information that is required to remain confidential, such information must be clearly identified and
88 the applicant shall submit duplicate applications, one with full information for the authority's use
89 and one redacted application available for release to the public.

90 (2) The authority shall upon receipt of a completed application, publish notification of the
91 application on its website as well as provide notice of such application placed in the State
92 Register. The public may submit written comments regarding the application within ten days
93 following publication. Following the close of the written comment period, the authority shall review
94 the application as set forth in this section. Within thirty days of the receipt of a complete
95 application the authority may:

96 (i) Issue a certificate of approval which shall contain any conditions the authority finds
97 necessary for the approval;

98 (ii) Deny the application; or

99 (iii) Order a public hearing if the authority finds it necessary to make an informed decision
100 on the application.

101 (3) The authority shall issue a written decision within seventy-five days from receipt of the
102 completed application. The authority may request additional information in which case they shall
103 have an additional fifteen days following receipt of the supplemental information to approve or
104 deny the proposed cooperative agreement.

105 (4) Notice of any hearing shall be sent by certified mail to the applicants and all persons,
106 groups or organizations who have submitted written comments on the proposed cooperative
107 agreement. Any individual, group or organization who submitted written comments regarding the
108 application and wishes to present evidence at the public hearing shall request to be recognized
109 as an affected party as set forth in article two-d of this chapter. The hearing shall be held no later

110 than forty-five days after receipt of the application. The authority shall publish notice of the hearing
111 on the authority's website fifteen days prior to the hearing. The authority shall additionally provide
112 timely notice of such hearing in the State Register.

113 (5) Parties may file a motion for an expedited decision.

114 (f) *Standards for review of cooperative agreements.* —

115 (1) In its review of an application for approval of a cooperative agreement submitted
116 pursuant to this section, the authority may consider the proposed cooperative agreement and any
117 supporting documents submitted by the applicant, any written comments submitted by any person
118 and any written or oral comments submitted, or evidence presented, at any public hearing.

119 (2) The authority shall consult with the Attorney General of this state regarding his or her
120 assessment of whether or not to approve the proposed cooperative agreement.

121 (3) The authority shall approve a proposed cooperative agreement and issue a certificate
122 of approval if it determines, with the written concurrence of the Attorney General, that the benefits
123 likely to result from the proposed cooperative agreement outweigh the disadvantages likely to
124 result from a reduction in competition from the proposed cooperative agreement.

125 (4) In evaluating the potential benefits of a proposed cooperative agreement, the authority
126 shall consider whether one or more of the following benefits may result from the proposed
127 cooperative agreement:

128 (A) Enhancement and preservation of existing academic and clinical educational
129 programs;

130 (B) Enhancement of the quality of hospital and hospital-related care, including mental
131 health services and treatment of substance abuse provided to citizens served by the authority;

132 (C) Enhancement of population health status consistent with the health goals established
133 by the authority;

134 (D) Preservation of hospital facilities in geographical proximity to the communities
135 traditionally served by those facilities to ensure access to care;

136 (E) Gains in the cost-efficiency of services provided by the hospitals involved;

137 (F) Improvements in the utilization of hospital resources and equipment;

138 (G) Avoidance of duplication of hospital resources;

139 (H) Participation in the state Medicaid program; and

140 (I) Constraints on increases in the total cost of care.

141 (5) The authority's evaluation of any disadvantages attributable to any reduction in
142 competition likely to result from the proposed cooperative agreement shall include, but need not
143 be limited to, the following factors:

144 (A) The extent of any likely adverse impact of the proposed cooperative agreement on the
145 ability of health maintenance organizations, preferred provider organizations, managed health
146 care organizations or other health care payors to negotiate reasonable payment and service
147 arrangements with hospitals, physicians, allied health care professionals or other health care
148 providers;

149 (B) The extent of any reduction in competition among physicians, allied health
150 professionals, other health care providers or other persons furnishing goods or services to, or in
151 competition with, hospitals that is likely to result directly or indirectly from the proposed
152 cooperative agreement;

153 (C) The extent of any likely adverse impact on patients in the quality, availability and price
154 of health care services; and

155 (D) The availability of arrangements that are less restrictive to competition and achieve
156 the same benefits or a more favorable balance of benefits over disadvantages attributable to any
157 reduction in competition likely to result from the proposed cooperative agreement.

158 (6) (A) After a complete review of the record, including, but not limited to, the factors set
159 out in subsection (e) of this section, any commitments made by the applicant or applicants and
160 any conditions imposed by the authority, if the authority determines that the benefits likely to result
161 from the proposed cooperative agreement outweigh the disadvantages likely to result from a

162 reduction in competition from the proposed cooperative agreement, the authority shall approve
163 the proposed cooperative agreement.

164 (B) The authority may reasonably condition approval upon the parties' commitments to:

165 (i) Achieving improvements in population health;

166 (ii) Access to health care services;

167 (iii) Quality and cost efficiencies identified by the parties in support of their application for
168 approval of the proposed cooperative agreement; and

169 (iv) Any additional commitments made by the parties to the cooperative agreement.

170 Any conditions set by the authority shall be fully enforceable by the authority. No condition
171 imposed by the authority, however, shall limit or interfere with the right of a hospital to adhere to
172 religious or ethical directives established by its governing board.

173 (7) The authority's decision to approve or deny an application shall constitute a final order
174 or decision pursuant to the West Virginia Administrative Procedure Act (§ 29A-1-1, *et seq.*). The
175 authority may enforce commitments and conditions imposed by the authority in the circuit court
176 of Kanawha County or the circuit court where the principal place of business of a party to the
177 cooperative agreement is located.

178 (g) *Enforcement and supervision of cooperative agreements.* — The authority shall
179 enforce and supervise any approved cooperative agreement for compliance.

180 (1) The authority is authorized to promulgate legislative rules in furtherance of this section.
181 Additionally, the authority shall promulgate emergency rules pursuant to the provisions of section
182 fifteen, article three, chapter twenty-nine-a of this code to accomplish the goals of this section.
183 These rules shall include, at a minimum:

184 (A) An annual report by the parties to a cooperative agreement. This report is required to
185 include:

186 (i) Information about the extent of the benefits realized and compliance with other terms
187 and conditions of the approval;

188 (ii) A description of the activities conducted pursuant to the cooperative agreement,
189 including any actions taken in furtherance of commitments made by the parties or terms imposed
190 by the authority as a condition for approval of the cooperative agreement;

191 (iii) Information relating to price, cost, quality, access to care and population health
192 improvement;

193 (iv) Disclosure of any reimbursement contract between a party to a cooperative agreement
194 approved pursuant to this section and a commercial health plan or insurer entered into
195 subsequent to the finalization of the cooperative agreement. This shall include the amount, if any,
196 by which an increase in the average rate of reimbursement exceeds, with respect to inpatient
197 services for such year, the increase in the Consumer Price Index for all Urban Consumers for
198 hospital inpatient services as published by the Bureau of Labor Statistics for such year and, with
199 respect to outpatient services, the increase in the Consumer Price Index for all Urban Consumers
200 for hospital outpatient services for such year; and

201 (v) Any additional information required by the authority to ensure compliance with the
202 cooperative agreement.

203 (B) If an approved application involves the combination of hospitals, disclosure of the
204 performance of each hospital with respect to a representative sample of quality metrics selected
205 annually by the authority from the most recent quality metrics published by the Centers for
206 Medicare and Medicaid Services. The representative sample shall be published by the authority
207 on its website.

208 (C) A procedure for a corrective action plan where the average performance score of the
209 parties to the cooperative agreement in any calendar year is below the fiftieth percentile for all
210 United States hospitals with respect to the quality metrics as set forth in (B) of this subsection.
211 The corrective action plan is required to:

212 (i) Be submitted one hundred twenty days from the commencement of the next calendar
213 year; and

214 (ii) Provide for a rebate to each commercial health plan or insurer with which they have
215 contracted an amount not in excess of one percent of the amount paid to them by such
216 commercial health plan or insurer for hospital services during such two-year period if in any two
217 consecutive-year period the average performance score is below the fiftieth percentile for all
218 United States hospitals. The amount to be rebated shall be reduced by the amount of any
219 reduction in reimbursement which may be imposed by a commercial health plan or insurer under
220 a quality incentive or awards program in which the hospital is a participant.

221 (D) A procedure where if the excess above the increase in the Consumer Price Index for
222 all Urban Consumers for hospital inpatient services or hospital outpatient services is two percent
223 or greater the authority may order the rebate of the amount which exceeds the respective indices
224 by two percent or more to all health plans or insurers which paid such excess unless the party
225 provides written justification of such increase satisfactory to the authority taking into account case
226 mix index, outliers and extraordinarily high cost outpatient procedure utilizations.

227 (E) The ability of the authority to investigate, as needed, to ensure compliance with the
228 cooperative agreement.

229 (F) The ability of the authority to take appropriate action, including revocation of a
230 certificate of approval, if it determines that:

231 (i) The parties to the agreement are not complying with the terms of the agreement or the
232 terms and conditions of approval;

233 (ii) The authority's approval was obtained as a result of an intentional material
234 misrepresentation;

235 (iii) The parties to the agreement have failed to pay any required fee; or

236 (iv) The benefits resulting from the approved agreement no longer outweigh the
237 disadvantages attributable to the reduction in competition resulting from the agreement.

238 (G) If the authority determines the parties to an approved cooperative agreement have
239 engaged in conduct that is contrary to state policy or the public interest, including the failure to

240 take action required by state policy or the public interest, the authority may initiate a proceeding
241 to determine whether to require the parties to refrain from taking such action or requiring the
242 parties to take such action, regardless of whether or not the benefits of the cooperative agreement
243 continue to outweigh its disadvantages. Any determination by the authority shall be final. The
244 authority is specifically authorized to enforce its determination in the circuit court of Kanawha
245 County or the circuit court where the principal place of business of a party to the cooperative
246 agreement is located.

247 (H) Fees as set forth in subsection (h).

248 (2) Until the promulgation of the emergency rules, the authority shall monitor and regulate
249 cooperative agreements to ensure that their conduct is in the public interest and shall have the
250 powers set forth in subdivision (1) of this subsection, including the power of enforcement set forth
251 in paragraph (G), subdivision (1) of this subsection.

252 (h) *Fees.* — The authority may set fees for the approval of a cooperative agreement.
253 These fees shall be for all reasonable and actual costs incurred by the authority in its review and
254 approval of any cooperative agreement pursuant to this section. These fees shall not exceed
255 \$75,000. Additionally, the authority may assess an annual fee not to exceed \$75,000 for the
256 supervision of any cooperative agreement approved pursuant to this section and to support the
257 implementation and administration of the provisions of this section.

258 (i) *Miscellaneous provisions.* —

259 (1) (A) An agreement entered into by a hospital party to a cooperative agreement and any
260 state official or state agency imposing certain restrictions on rate increases shall be enforceable
261 in accordance with its terms and may be considered by the authority in determining whether to
262 approve or deny the application. Nothing in this chapter shall undermine the validity of any such
263 agreement between a hospital party and the Attorney General entered before the effective date
264 of this legislation.

265 (B) At least ninety days prior to the implementation of any increase in rates for inpatient
266 and outpatient hospital services and at least sixty days prior to the execution of any
267 reimbursement agreement with a third party payor, a hospital party to a cooperative agreement
268 involving the combination of two or more hospitals through merger, consolidation or acquisition
269 which has been approved by the authority shall submit any proposed increase in rates for inpatient
270 and outpatient hospital services and any such reimbursement agreement to the Office of the West
271 Virginia Attorney General together with such information concerning costs, patient volume, acuity,
272 payor mix and other data as the Attorney General may request. Should the Attorney General
273 determine that the proposed rates may inappropriately exceed competitive rates for comparable
274 services in the hospital's market area which would result in unwarranted consumer harm or impair
275 consumer access to health care, the Attorney General may request the authority to evaluate the
276 proposed rate increase and to provide its recommendations to the Office of the Attorney General.
277 The Attorney General may approve, reject or modify the proposed rate increase and shall
278 communicate his or her decision to the hospital no later than 30 days prior to the proposed
279 implementation date. The hospital may then only implement the increase approved by the
280 Attorney General. Should the Attorney General determine that a reimbursement agreement with
281 a third party payor includes pricing terms at anti-competitive levels, the Attorney General may
282 reject the reimbursement agreement and communicate such rejection to the parties thereto
283 together with the rationale therefor in a timely manner.

284 (2) The authority shall maintain on file all cooperative agreements the authority has
285 approved, including any conditions imposed by the authority.

286 (3) Any party to a cooperative agreement that terminates its participation in such
287 cooperative agreement shall file a notice of termination with the authority thirty days after
288 termination.

289 (4) No hospital which is a party to a cooperative agreement for which approval is required
290 pursuant to this section may knowingly bill or charge for health services resulting from, or

291 associated with, such cooperative agreement until approved by the authority. Additionally, no
292 hospital which is a party to a cooperative agreement may knowingly bill or charge for health
293 services resulting from, or associated with, such cooperative agreement for which approval has
294 been revoked or terminated.

295 (5) By submitting an application for review of a cooperative agreement pursuant to this
296 section, the hospitals or health care providers shall be deemed to have agreed to submit to the
297 regulation and supervision of the authority as provided in this section.

§16-29B-30. Applicability; transition plan.

1 (a) Notwithstanding any provision of this code to the contrary, effective July 1, 2017, the
2 Health Care Authority shall transfer to the Department of Health and Human and Resources. Any
3 and all remaining functions of the Health Care Authority shall transfer at that time to the
4 Department of Health and Human Resources.

5 (b) The Health Care Authority shall develop and implement a transition plan to transfer all
6 their remaining functions to the Department of Health and Human Resources. The plan shall be
7 submitted in writing to the Joint Committee on Government and Finance, the Governor and the
8 Secretary of the Department of Health and Human Resources, the Secretary of the Department
9 of Administration and the Division of Personnel. This plan shall be submitted no later than June
10 1, 2017. The plan shall include proposals for the following:

11 (1) Transition to appropriate entities or destruction of hard and electronic copies of files;

12 (2) Transfer of all certificate of need matters pending as of July 1, 2017, to the Department
13 of Health and Human Resources.

14 (3) In consultation with the Department of Administration, discontinuation of use of the
15 current building including termination of any lease or rental agreements, if necessary;

16 (4) In consultation with the Department of Administration, disposition of all state owned or
17 leased office furniture and equipment, including any state owned vehicles, if necessary;

18 (5) Closing out and transferring existing budget allocations;

19 (6) A transition plan developed in conjunction with the Division of Personnel for remaining
20 employees not transferred to other offices within state government;

21 (7) A plan to repeal all existing legislative rules made unnecessary by the transfer of the
22 Health Care Authority; and

23 (8) Any other matters which would effectively terminate all functions not transferred to the
24 Department of Health and Human Resources.

25 (9) Upon the effective date of the changes to this article made during the course of the
26 2017 Regular Session of the Legislature, any function of the Health Care Authority not otherwise
27 eliminated or transferred shall become a function of the Department of Health and Human
28 Resources.

ARTICLE 29G. WEST VIRGINIA HEALTH INFORMATION NETWORK.

§16-29G-1a. Transfer of West Virginia Health Information Network.

1 (a) As used in this article, the following mean:

2 (1) "Agreement" means a document that may be entered into between the network board
3 and the corporation;

4 (2) "Assets" means the tangible and intangible personal property of the network on the
5 transfer date, including all assignable grants, all obligated funds on deposit in the network
6 account, agreements and contracts;

7 (3) "Corporation" means any nonstock, nonprofit corporation to be established under the
8 chapter thirty-one;

9 (4) "Network" means the West Virginia Health Information Network; and

10 (5) "Network account" means the West Virginia Health Information Network Account.

11 (b) By December 31, 2017, the network board of directors shall transfer the existing
12 network, the associated assets and liabilities to a private nonprofit corporation organized under
13 chapter thirty-one e of this code.

14 (c) The network board of directors may enter into agreements as they determine are
15 appropriate to implement the transfer. The agreements are exempt from the bidding and public
16 sale requirements, from the approval of contractual agreements by the Department of
17 Administration or the Attorney General and from the requirements of chapter five-a of this code.

18 (d) The initial corporation board of directors may consist of any current members of the
19 network board of directors. The current appointed network directors shall continue to serve until
20 the transfer is complete. Notwithstanding any other provisions of this code to the contrary, officers
21 and employees of the network may be transferred considered for employment with to the
22 corporation, and any such employment shall be deemed exempt from the requirements and
23 limitations imposed by section five, article two, chapter six-B and any legislative rules promulgated
24 thereunder.

25 (e) The corporation shall have all powers afforded to a nonprofit corporation by law and is
26 limited to those powers enumerated in this article.

27 (f) The corporation shall not be a department, unit, agency or instrumentality of the state.

28 (g) The corporation is not subject to the provisions of article nine-a, chapter six of this
29 code, Open Government Proceeding; the provisions of article two, chapter six-c of this code, the
30 West Virginia Public Employees Grievance Procedure; the provisions of article six, chapter
31 twenty-nine of this code, Civil Service System; or the provisions of chapter twenty-nine-b of this
32 code, Freedom of Information; article twelve, chapter twenty-nine of this code, State Insurance;
33 article ten, chapter five, of this code, West Virginia Public Employees Retirement Act, or the
34 provisions of article sixteen, chapter five, of this code, West Virginia Public Employees Insurance
35 Act.

36 (h) The Secretary of the Department of Health and Human Resources may designate the
37 corporation as the state's health information exchange, and shall have the authority to make sole
38 source grants or enter into sole source contracts with the corporation pursuant to section ten-c,
39 article three, chapter five-A of this code.

40 (i) The Secretary of the Department of Health and Human Resources shall have access
41 to the data free of charge subject to the provisions of applicable state and federal law.

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

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

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

17 (c) Notwithstanding section ten, article three, chapter twelve of this code, on the transfer
18 date, the encumbered amounts on deposit in the West Virginia Health Information Network
19 Account shall be paid over to the corporation, the account shall be closed and subsection (a) of
20 this section shall be of no further effect.

CHAPTER 21. LABOR.

ARTICLE 5. NURSE OVERTIME AND PATIENT SAFETY ACT.

§21-5F-4. Enforcement; offenses and penalties.

1 (a) Pursuant to the powers set forth in article one of this chapter, the Commissioner of
2 Labor is charged with the enforcement of this article. The commissioner shall propose legislative
3 and procedural rules in accordance with the provisions of article three, chapter twenty-nine-a of
4 this code to establish procedures for enforcement of this article. These rules shall include, but are
5 not limited to, provisions to protect due process requirements, a hearings procedure, an appeals
6 procedure, and a notification procedure, including any signs that must be posted by the facility.

7 (b) Any complaint must be filed with the commissioner regarding an alleged violation of
8 the provisions of this article must be made within thirty days following the occurrence of the
9 incident giving rise to the alleged violation. The commissioner shall keep each complaint
10 anonymous until the commissioner finds that the complaint has merit. The commissioner shall
11 establish a process for notifying a hospital of a complaint.

12 (c) The administrative penalty for the first violation of this article is a reprimand.

13 (d) The administrative penalty for the second offense of this article is a reprimand and a
14 fine not to exceed \$500.

15 (e) The administrative penalty for the third and subsequent offenses is a fine of not less
16 than \$2,500 and not more than \$5,000 for each violation.

17 (f) To be eligible to be charged of a second offense or third offense under this section, the
18 subsequent offense must occur within twelve months of the prior offense.

19 (g) All moneys paid as administrative penalties pursuant to this section shall be deposited
20 into the General Revenue Fund.

CHAPTER 33. INSURANCE.

ARTICLE 16D. MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER ACCIDENT AND SICKNESS INSURANCE POLICIES.

§33-4A-1. Definitions.

21 (a) "All-payer claims database" or "APCD" means the program authorized by this article
22 that collects, retains, uses and discloses information concerning the claims and administrative
23 expenses of health care payers.

24 (b) "Commissioner" means the West Virginia Insurance Commissioner.

25 (c) "Data" means the data elements from enrollment and eligibility files, specified types of
26 claims, and reference files for data elements not maintained in formats consistent with national
27 coding standards.

28 (d) "Executive Director" means the executive director of the West Virginia Health Care
29 Authority.

30 (e) "Health care payer" means any entity that pays or administers the payment of health
31 insurance claims or medical claims under workers' compensation insurance to providers in this
32 state, including workers' compensation insurers; accident and sickness insurers; nonprofit
33 hospital service corporations, medical service corporations and dental service organizations;
34 nonprofit health service corporations; prepaid limited health service organizations; health
35 maintenance organizations; and government payers, including but not limited to Medicaid,
36 Medicare and the public employees insurance agency; the term also includes any third-party
37 administrator including any pharmacy benefit manager, that administers a fully-funded or self-
38 funded plan:

39 A "health insurance claim" does not include:

40 (1) Any claim paid under an individual or group policy providing coverage only for accident,
41 or disability income insurance or any combination thereof; coverage issued as a supplement to

42 liability insurance; liability insurance, including general liability insurance and automobile
43 liability; credit-only insurance; coverage for on-site medical clinics; other similar insurance
44 coverage, which may be specified by rule, under which benefits for medical care are secondary
45 or incidental to other insurance benefits; or

46 (2) Any of the following if provided under a separate policy, certificate, or contract of
47 insurance: Limited scope dental or vision benefits; benefits for long-term care, nursing home care,
48 home health care, community-based care, or any combination thereof; coverage for only a
49 specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

50 "Health insurance claims" shall only include information from Medicare supplemental
51 policies if the same information is obtained with respect to Medicare.

52 (f) "Personal identifiers" means information relating to an individual member or insured
53 that identifies, or can be used to identify, locate or contact a particular individual member or
54 insured, including but not limited to the individual's name, street address, social security number,
55 e-mail address and telephone number.

56 (g) "Secretary" means the Secretary of the West Virginia Department of Health and Human
57 Services.

58 (h) "Third-party administrator" has the same meaning ascribed to it in section two, article
59 forty-six of this chapter.

§33-4A-2. Establishment and development of an all-payer claims database.

1 (a) The secretary, commissioner and the executive director, collectively referred to herein
2 as the "MOU parties", shall enter into a memorandum of understanding to develop an all-payer
3 claims database program.

4 (b) The memorandum of understanding shall, at a minimum:

5 (1) Provide that the commissioner will have primary responsibility for the collection of the
6 data in order to facilitate the efficient administration of state oversight, the secretary will have
7 primary responsibility for the retention of data supplied to the state under its health care oversight

8 function, and the executive director will have primary responsibility for the dissemination of the
9 data;

10 (2) Delineate the MOU parties' roles, describe the process to develop legislative rules
11 required by this article, establish communication processes and a coordination plan, and address
12 vendor relationship management;

13 (3) Provide for the development of a plan for the financial stability of the APCD, including
14 provision for funding by the MOU parties' agencies; and

15 (4) Provide for the use of the hospital discharge data collected by the West Virginia Health
16 Care Authority as a tool in the validation of APCD reports.

**§33-4A-3. Powers of the commissioner, secretary and executive director; exemption from
purchasing rules.**

1 (a) The MOU parties may:

2 (1) Accept gifts, bequests, grants or other funds dedicated to the furtherance of the goals
3 of the APCD;

4 (2) Select a vendor to handle data collection and processing and such other tasks as
5 deemed appropriate;

6 (3) Enter into agreements with other states to perform joint administrative operations,
7 share information and assist in the development of multistate efforts to further the goals of this
8 article: *Provided*, That any such agreements must include adequate protections with respect to
9 the confidentiality of the information to be shared and comply with all state and federal laws and
10 regulations;

11 (4) Enter into memoranda of understanding with other governmental agencies to carry out
12 any of its functions, including contracts with other states to perform joint administrative functions;

13 (5) Attempt to ensure that the requirements with respect to the reporting of data be
14 standardized so as to minimize the expense to parties subject to similar requirements in other
15 jurisdictions;

16 (6) Enter into voluntary agreements to obtain data from payers not subject to mandatory
17 reporting under this article; and

18 (7) Exempt a payer or class of payers from the requirements of this article for cause.

19 (b) Contracts for professional services for the development and operation of the APCD
20 are not subject to the provisions of article three, chapter five-a of this code relating to the
21 Purchasing Division of the Department of Administration. The award of such contracts shall be
22 subject to a competitive process established by the MOU parties.

23 (c) The MOU parties shall make an annual report to the Governor, which shall also be filed
24 with the Joint Committee on Government and Finance, summarizing the activities of the APCD in
25 the preceding calendar year.

§33-4A-5. User fees; waiver.

1 Reasonable user fees may be set in the manner established in legislative rule, for the right
2 to access and use the data available from the APCD. The executive director may reduce or waive
3 the fee if he or she determines that the user is unable to pay the scheduled fees and that the user
4 has a viable plan to use the data or information in research of general value to the public health.

§33-4A-6. Enforcement; injunctive relief.

1 In the event of any violation of this article or any rule adopted thereunder, the
2 commissioner, secretary or executive director may seek to enjoin a further violation in the circuit
3 court of Kanawha County. Injunctive relief ordered pursuant to this section may be in addition to
4 any other remedies and enforcement actions available to the commissioner under this chapter.

§33-4A-7. Special revenue account created.

1 (a) There is hereby created a special revenue account in the State Treasury, designated
2 the West Virginia All-Payer Claims Database Fund, which shall be an interest-bearing account
3 and may be invested in the manner permitted by article six, chapter twelve of this code, with the
4 interest income a proper credit to the fund and which shall not revert to the general revenue,
5 unless otherwise designated in law. The fund shall be overseen by the commissioner, secretary

6 and executive director, shall be administered by the commissioner, and shall be used to pay all
7 proper costs incurred in implementing the provisions of this article.

8 (b) The following funds shall be paid into this account:

9 (1) Penalties imposed on health care payers pursuant to this article and rules promulgated
10 hereunder;

11 (2) Funds received from the federal government;

12 (3) Appropriations from the Legislature; and

13 (4) All other payments, gifts, grants, bequests or income from any source.

**ARTICLE 16D. MARKETING AND RATE PRACTICES FOR SMALL EMPLOYER
ACCIDENT AND SICKNESS INSURANCE POLICIES.**

§33-16D-16. Authorization of uninsured small group health benefit plans.

1 (a) Upon filing with and approval by the commissioner, any carrier licensed pursuant to
2 this chapter which accesses a health care provider network to deliver services may offer a health
3 benefit plan and rates associated with the plan to a small employer subject to the conditions of
4 this section and subject to the provisions of this article. The health benefit plan is subject to the
5 following conditions:

6 (1) The health benefit plan may be offered by the carrier only to small employers which
7 have not had a health benefit plan covering their employees for at least six consecutive months
8 before the effective date of this section. After the passage of six months from the effective date
9 of this section, the health benefit plan under this section may be offered by carriers only to small
10 employers which have not had a health benefit plan covering their employees for twelve
11 consecutive months;

12 (2) If a small employer covered by a health benefit plan offered pursuant to this section no
13 longer meets the definition of a small employer as a result of an increase in eligible employees,
14 that employer shall remain covered by the health benefit plan until the next annual renewal date;

15 (3) The small employer shall pay at least fifty percent of its employees' premium amount
16 for individual employee coverage;

17 (4) The commissioner shall promulgate emergency rules under the provisions of article
18 three, chapter twenty-nine-a of this code on or before September 1, 2004, to place additional
19 restrictions upon the eligibility requirements for health benefit plans authorized by this section in
20 order to prevent manipulation of eligibility criteria by small employers and otherwise implement
21 the provisions of this section;

22 (5) Carriers must offer the health benefit plans issued pursuant to this section through one
23 of their existing networks of health care providers;

24 (A) The Insurance Commission shall, on or before May 1, 2004, and each year thereafter,
25 by regular mail, provide a written notice to all known in-state health care providers that:

26 (i) Informs the health care provider regarding the provisions of this section; and

27 (ii) Notifies the health care provider that if the health care provider does not give written
28 refusal to the Insurance Commission within thirty days from receipt of the notice or the health care
29 provider has not previously filed a written notice of refusal to participate, the health care provider
30 must participate with and accept the products and provider reimbursements authorized pursuant
31 to this section;

32 (B) The carrier's network of health care providers, as well as any health care provider
33 which provides health care goods or services to beneficiaries of any departments or divisions of
34 the state, as identified in article twenty-nine-d, chapter sixteen of this code, shall accept the health
35 care provider reimbursement rates set pursuant to this section unless the health care provider
36 gives written refusal to the Insurance Commission between May 1 and June 1 that the provider
37 will not participate in this program for the next calendar year. Notwithstanding any provision of
38 this code to the contrary, health care providers may not be mandated to participate in this program
39 except under the opt-out provisions of subdivision (5), subsection (a) of this section and therefore
40 the health care provider shall annually have the ability to file with the Insurance Commission

41 written notice that the health care provider will not participate with products issued pursuant to
42 this section. Once a health care provider has filed a notice of refusal with the Insurance
43 Commission, the notice shall remain effective until rescinded by the provider and the provider
44 shall not be required to renew the notice each year;

45 (C) Insurance Commission is responsible for receiving the responses, if any, from the
46 health care providers that have elected not to participate and for providing a list to the
47 commissioner of those health care providers that have elected not to participate;

48 (D) Those health care providers that do not file a notice of refusal shall be considered to
49 have accepted participation in this program and to accept Public Employees Insurance Agency
50 health care provider reimbursement rates for their services as set by this section;

51 (E) Health care provider reimbursement rates used by the carrier for a health benefit plan
52 offered pursuant to this section shall have no effect on provider rates for other products offered
53 by the carrier and most-favored-nation clauses do not apply to the rates;

54 (6) With respect to the health benefit plans authorized by this section, the carrier shall
55 reimburse network health care providers at the same health care provider reimbursement rates
56 in effect for the managed care and health maintenance organization plans offered by the West
57 Virginia Public Employees Insurance Agency. Beginning in the year 2004, and in each year
58 thereafter, the health care provider reimbursement rates set under this section may not be
59 lowered from the level of the rates in effect on July 1 of that year for the managed care and health
60 maintenance plans offered by the Public Employees Insurance Agency. While it is the intent of
61 this paragraph to govern rates for plans offered pursuant to this section for annual periods, this
62 subdivision in no way prevents the Public Employees Insurance Agency from making provider
63 reimbursement rate adjustments to Public Employees Insurance Agency plans during the course
64 of each year. If there is a dispute regarding the determination of appropriate rates pursuant to this
65 section, the Director of the Public Employees Insurance Agency shall, in his or her sole discretion,
66 specify the appropriate rate to be applied;

67 (A) The health care provider reimbursement rates as authorized by this section shall be
68 accepted by the health care provider as payment in full for services or products provided to a
69 person covered by a product authorized by this section;

70 (B) Except for the health care provider rates authorized under this section, a carrier's
71 payment methodology, including copayments and deductibles and other conditions of coverage,
72 remains unaffected by this section;

73 (C) The provisions of this section do not require the Public Employees Insurance Agency
74 to give carriers access to the purchasing networks of the Public Employees Insurance Agency.
75 The Public Employees Insurance Agency may enter into agreements with carriers offering health
76 benefit plans under this section to permit the carrier, at its election, to participate in drug
77 purchasing arrangements pursuant to article sixteen-c, chapter five of this code, including the
78 multistate drug purchasing program. This paragraph provides authorization of the agreements
79 pursuant to section four of said article;

80 (7) Carriers may not underwrite products authorized by this section more strictly than other
81 small group policies governed by this article;

82 (8) With respect to health benefit plans authorized by this section, a carrier shall have a
83 minimum anticipated loss ratio of seventy-seven percent to be eligible to make a rate increase
84 request after the first year of providing a health benefit plan under this section;

85 (9) Products authorized under this section are exempt from the premium taxes assessed
86 under sections fourteen and fourteen-a, article three of this chapter;

87 (10) A carrier may elect to nonrenew any health benefit plan to an eligible employer if, at
88 any time, the carrier determines, by applying the same network criteria which it applies to other
89 small employer health benefit plans, that it no longer has an adequate network of health care
90 providers accessible for that eligible small employer. If the carrier makes a determination that an
91 adequate network does not exist, the carrier has no obligation to obtain additional health care
92 providers to establish an adequate network;

93 (11) Upon thirty days' advance notice to the commissioner, a carrier may, at any time,
94 elect to nonrenew all health benefit plans issued pursuant to this section. If a carrier nonrenews
95 all its business issued pursuant to this section for any reason other than the adequacy of the
96 provider network, the carrier may not offer this health benefit plan to any eligible small employer
97 for a period of at least two years after the last eligible small employer is nonrenewed; and

98 (12) The Insurance Commissioner may not approve any health benefit plan issued
99 pursuant to this section until it has obtained any necessary federal governmental authorizations
100 or waivers. The Insurance Commissioner shall apply for and obtain all necessary federal
101 authorizations or waivers.

102 (b) Health benefit plans authorized by this section are not intended to violate the
103 prohibition set out in subsection (a), section four of this article.

104 (c) Carriers offering health benefit plans pursuant to this section shall annually or before
105 December 1 of each year report in a form acceptable to the commissioner the number of health
106 benefit plans written by the carrier and the number of individuals covered under the health benefit
107 plans.

108 (d) To the extent that provisions of this section differ from those contained elsewhere in
109 this chapter, the provisions of this section control.


The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

FILED

2017 APR 10 P 3:29

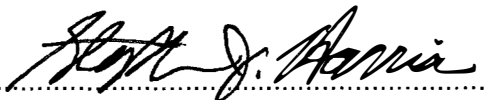
OFFICE WEST VIRGINIA
SECRETARY OF STATE


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Vice-Chairman, House Committee



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Chairman, Senate Committee

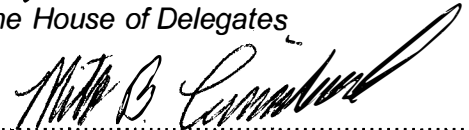
Originating in the House.

In effect from passage.

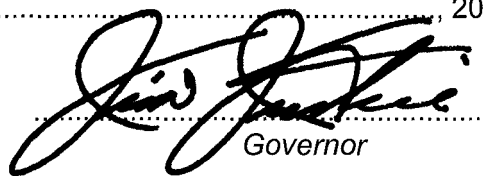

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Clerk of the House of Delegates


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Clerk of the Senate


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Speaker of the House of Delegates


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President of the Senate

The within is approved this the 10th
April
day of, 2017.


.....
Governor

PRESENTED TO THE GOVERNOR

APR 04 2017

Time 8:57 am