WEST VIRGINIA LEGISLATURE

2026 REGULAR SESSION

Introduced

House Bill 4917

By Delegates Anders, White, Coop-Gonzalez, and Kump

[Introduced January 29, 2026; referred to the Committee on Health and Human Resources]

A BILL to amend and reenact §9-5-19, §16-2D-1, §16-2D-2, §16-2D-4, §16-2D-5, §16-2D-16a, §16-29B-1, §16-29B-3, §16-29B-8, §16-29B-25, §16-29B-26, §16-29B-28, §33-15B-5, and §51-11-4 of the Code of West Virginia, 1931, as amended; and to repeal §16-2D-3, §16-2D-6, §16-2D-7, §16-2D-8, §16-2D-9, §16-2D-10, §16-2D-11, §16-2D-12, §16-2D-13, §16-2D-14, §16-2D-15, §16-2D-16, §16-2D-17, §16-2D-18, §16-2D-19, §16-2D-20, §16-29A-20, §16-29B-2, §16-29B-5, §16-29B-5a, §16-29B-12, §16-29B-13, §16-29B-14, §16-29B-15, §16-29B-24, §16-29B-30, §16-29B-31, §16B-13-12, §16B-21-3, and §49-2-124, relating to the termination of the West Virginia Health Care Authority; providing the termination of the authority's certificate of need program; providing the termination of the authority's cooperative agreement review process; providing definitions; establishing when the secretary shall propose a repeal; clarifying the transfer of the authority's remaining powers, assets, records, and employees to the Secretary of the Department of Health; clarifying the money to be transferred to the general revenue fund; and establishing exemptions.

Be it enacted by the Legislature of West Virginia:

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§9-5-19. Summary review for certain behavioral health facilities and services.

(a) ~~A certificate of need as provided in article two-d, chapter sixteen of this code is not required by an entity proposing additional behavioral health care services, but only~~ The secretary shall perform a summary review in accordance with the provisions of this section for any entity proposing additional health care services to the extent necessary to gain federal approval of the Medicaid MR/DD waiver program~~, if a summary review is performed in accordance with the provisions of this section~~.

(b) Prior to initiating any summary review, the secretary shall direct the revision of the state

mental health plan as required by the provisions of 42 U.S.C. 300x and §27-1A-4 of this code. In developing those revisions, the secretary is to appoint an advisory committee composed of representatives of the associations representing providers, child care providers, physicians and advocates. The secretary shall appoint the appropriate department employees representing regulatory agencies, reimbursement agencies and oversight agencies of the behavioral health system.

(c) If the secretary determines that specific services are needed but unavailable, he or she shall provide notice of the department's intent to develop those services. Notice may be provided through publication in the state register, publication in newspapers or a modified request for proposal as developed by the secretary.

(d) The secretary may initiate a summary review of additional behavioral health care services, but only to the extent necessary to gain federal approval of the Medicaid MR/DD waiver program~~, by recommending exemption from the provisions of article two-d, chapter sixteen of this code to the Health Care Authority~~. The recommendation is to include the following findings:

(1) That the proposed service is consistent with the state health plan and the state mental health plan;

(2) That the proposed service is consistent with the department's programmatic and fiscal plan for behavioral health services;

(3) That the proposed service contributes to providing services that prevent admission to restrictive environments or enables an individual to remain in a nonrestrictive environment;

(4) That the proposed service contributes to reducing the number of individuals admitted to inpatient or residential treatment programs or services;

(5) If applicable, that the proposed service will be community-based, locally accessible, provided in an appropriate setting consistent with the unique needs and potential of each client and his or her family and located in an area that is unserved or underserved or does not allow consumers a choice of providers; and

(6) That the secretary is determining that sufficient funds are available for the proposed service without decreasing access to or provision of existing services. The secretary may, from time to time, transfer funds pursuant to the general provisions of the budget bill.

(e) The secretary's findings required by this section shall be filed with the secretary's recommendation and appropriate documentation. ~~If the secretary's findings are supported by the accompanying documentation, the proposal does not require a certificate of need.~~

~~(f) Any entity that does not qualify for summary review is subject to a certificate of need review.~~

~~(g) Any provider of the proposed services denied authorization to provide those services pursuant to the summary review has the right to appeal that decision to the state agency in accordance with the provisions of §16-2d-10 of this code.~~

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2D. CERTIFICATE OF NEED.

§16-2D-1. Legislative findings.

~~It is declared to be the public policy of this state:~~

~~(1) That the offering or development of all health services shall be accomplished in a manner which is orderly, economical and consistent with the effective development of necessary and adequate means of providing for the health services of the people of this state and to avoid unnecessary duplication of health services, and to contain or reduce increases in the cost of delivering health services.~~

~~(2) That the general welfare and protection of the lives, health and property of the people of this state require that the type, level and quality of care, the feasibility of providing such care and other criteria as provided for in this article, including certificate of need standards and criteria developed by the authority pursuant to provisions of this article, pertaining to health services within this state, be subject to review and evaluation before any health services are offered or developed~~

~~in order that appropriate and needed health services are made available for persons in the area to be served.~~

Notwithstanding any other provision of this code to the contrary, no health care facility or otherwise covered facility may be required to obtain a certificate of need to operate in this state. On January 1, 2027, the certificate of need program authorized by this article shall be terminated and have no force and effect.

§16-2D-2. Definitions.

As used in this article:

~~(1) "Affected person" means:~~

~~(A) The applicant;~~

~~(B) An agency or organization representing consumers;~~

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

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

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

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

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

~~(H) An organization representing health care providers;~~

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

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

~~(4) "Applicant" means a person applying for a certificate of need, exemption or~~

~~determination of review;~~

~~(5)~~ "Authority" means the West Virginia Health Care Authority as provided in §16-29B-1 *et seq*. of this code;

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

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

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

~~(9) "Campus" means the physical area immediately adjacent to the hospital's main buildings, other areas, and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings;~~

~~(10) "Capital expenditure" means:~~

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

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

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

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

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

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

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

~~(C) A series of expenditures, if the sum total exceeds the expenditure minimum and if~~

~~determined by the authority to be a single capital expenditure subject to review. In making this determination, the authority shall consider: Whether the expenditures are for components of a system which is required to accomplish a single purpose; or whether the expenditures are to be made within a two-year period within a single department such that they will constitute a significant modernization of the department.~~

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

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

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

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

~~(15) "Expenditure minimum" means the cost of acquisition, improvement, expansion of any facility, equipment, or services including the cost of any studies, surveys, designs, plans, working drawings, specifications and other activities, including staff effort and consulting at and above $100 million;~~

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

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

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

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

(A) Home health aide services;

(B) Physical therapy;

(C) Speech therapy;

(D) Occupational therapy;

(E) Nutritional services; or

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

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

~~(21)~~ "Hospital" means a facility licensed pursuant to the provisions of §16-5B-1 *et seq*. of this code and any acute care facility operated by the state government, that primarily provides inpatient diagnostic, treatment or rehabilitative services to injured, disabled, or sick persons under the supervision of physicians.

~~(22)~~ "Hospital services" means services provided primarily to an inpatient to include, but not be limited to, preventative, diagnostic, treatment, or rehabilitative services provided in various departments on a hospital's campus;

~~(23)~~ "Intermediate care facility" means an institution that provides health-related services to individuals with conditions that require services above the level of room and board, but do not require the degree of services provided in a hospital or skilled-nursing facility.

~~(24) "Inpatient" means a patient whose medical condition, safety, or health would be significantly threatened if his or her care was provided in a less intense setting than a hospital. This~~

~~patient stays in the hospital overnight.~~

~~(25) "Like equipment" means medical equipment in which functional and technological capabilities are similar to the equipment being replaced; and the replacement equipment is to be used for the same or similar diagnostic, therapeutic, or treatment purposes as currently in use; and it does not constitute a substantial change in health service or a proposed health service.~~

~~(26) "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions which is used for the provision of medical and other health services and costs in excess of the expenditure minimum. This term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and it has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs ten and eleven, Section 1861(s) of such act, Title 42 U.S.C. § 1395x. In determining whether medical equipment is major medical equipment, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition of such equipment shall be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.~~

~~(27) "Medically underserved population" means the population of an area designated by the authority as having a shortage of a specific health service.~~

~~(28) "Nonhealth-related project" means a capital expenditure for the benefit of patients, visitors, staff or employees of a health care facility and not directly related to health services offered by the health care facility.~~

~~(29) "Offer" means the health care facility holds itself out as capable of providing, or as having the means to provide, specified health services.~~

~~(30)~~ "Opioid treatment program" means as that term is defined in §16-5Y-1 *et seq*. of this code.

~~(31)"Person" means an individual, trust, estate, partnership, limited liability corporation,~~

~~committee, corporation, governing body, association and other organizations such as joint-stock companies and insurance companies, a state or a political subdivision or instrumentality thereof or any legal entity recognized by the state.~~

~~(32)~~ "Personal care agency" means an entity that provides personal care services approved by the Bureau of Medical Services.

~~(33)~~ "Personal care services" means personal hygiene; dressing; feeding; nutrition; environmental support and health-related tasks provided by a personal care agency.

~~(34) "Physician" means an individual who is licensed to practice allopathic medicine by the Board of Medicine or licensed to practice osteopathic medicine by the Board of Osteopathic Medicine.~~

~~(35) "Proposed health service" means any service as described in §16-2D-8 of this code.~~

~~(36) "Purchaser" means an individual who is directly or indirectly responsible for payment of patient care services rendered by a health care provider, but does not include third-party payers.~~

~~(37) "Rates" means charges imposed by a health care facility for health services.~~

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

~~(39)~~ "Rehabilitation facility" means an inpatient facility licensed in West Virginia operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services.

~~(40)~~ "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a health care facility through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners, including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For

the purposes of this subdivision "family members" means parents, children, brothers and sisters whether by the whole or half blood, spouse, ancestors, and lineal descendants.

~~(41)~~ "Secretary" means the Secretary of the West Virginia Department of Health~~;~~.

~~(42) "Skilled nursing facility" means an institution, or a distinct part of an institution, that primarily provides inpatient skilled nursing care and related services, or rehabilitation services, to injured, disabled or sick persons.~~

~~(43) "Standard'' means a health service guideline developed by the authority and instituted under §16-2D-6 of this code.~~

~~(44) "State health plan" means a document prepared by the authority that sets forth a strategy for future health service needs in this state.~~

~~(45) "Substantial change to the bed capacity" of a health care facility means any change, associated with a capital expenditure, that increases or decreases the bed capacity or relocates beds from one physical facility or site to another, but does not include a change by which a health care facility reassigns existing beds.~~

~~(46) "Substantial change to the health services" means:~~

~~(A) The addition of a health service offered by or on behalf of the health care facility which was not offered by or on behalf of the facility within the 12-month period before the month in which the service was first offered; or~~

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

~~(47) "Telehealth" means the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.~~

~~(48) "Third-party payor" means an individual, person, corporation or government entity responsible for payment for patient care services rendered by health care providers.~~

~~(49) "To develop" means to undertake those activities which upon their completion will result in the offer of a proposed health service or the incurring of a financial obligation in relation to the offering of such a service.~~

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

[Repealed.]

§16-2D-4. Rulemaking.

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

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

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

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

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

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

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

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

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

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

The secretary shall propose a repeal, pursuant to either §29A-3-1a(b) or §29A-3-8(c) of the code, as appropriate, of any rule promulgated by the authority pursuant to this section to be considered by the Legislature during the 2027 regular session of the Legislature.

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

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

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

After January 1, 2027, any remaining balance in the "Certificate of Need Program Fund" shall be transferred to the General Revenue Fund of the State.

§16-2D-6. Changes to certificate of need standards.

[Repealed.]

§16-2D-7. Determination of reviewability.

[Repealed.]

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

[Repealed.]

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

[Repealed.]

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

[Repealed.]

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

[Repealed.]

§16-2D-12. Minimum criteria for certificate of need reviews.

[Repealed.]

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

[Repealed.]

§16-2D-14. Procedure for an uncontested application for a certificate of need.

[Repealed.]

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

[Repealed.]

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

[Repealed.]

§16-2D-16a. Transfer of appellate jurisdiction to Intermediate Court of Appeals.

(a) Notwithstanding any other provision of this article, effective July 1, 2022:

(1) The Office of Judges may not review a decision of the authority, issued after June 30, 2022, in a certificate of need review. On or before September 30, 2022, the Office of Judges shall issue a final decision in, or otherwise dispose of, each and every appeal, pending before the Office of Judges, of a decision by the authority in a certificate of need review.

(2) An appeal of a final decision in a certificate of need review, issued by the authority after June 30, 2022, shall be made to the West Virginia Intermediate Court of Appeals, pursuant to the provisions governing the judicial review of contested administrative cases in §29A-5-1 *et seq*. of this code.

(b) If the Office of Judges does not issue a final decision or otherwise dispose of any appeal of a decision of the authority in a certificate of need review on or before September 30,

2022, the appeal shall be transferred to the Intermediate Court of Appeals, as provided in §29A-5-4 of this code. For any appeal transferred pursuant to this subsection, the Intermediate Court of Appeals shall adopt any existing records of evidence and proceedings in the Office of Judges, conduct further proceedings as it considers necessary, and issue a final decision or otherwise dispose of the case pursuant to the provisions governing the judicial review of contested administrative cases in §29A-5-1 *et seq*. of this code.

(c) On and after January 1, 2027, no health care facility or otherwise covered facility may be required to obtain a certificate of need pursuant to this article.

§16-2D-17. Nontransference, time period compliance and withdrawal of certificate of need.

[Repealed.]

§16-2D-18. Denial or revocation of license for operating without certificate.

[Repealed.]

§16-2D-19. Injunctive relief; civil penalty.

[Repealed.]

§16-2D-20. Statute of limitations.

[Repealed.]

ARTICLE 29A. WEST VIRGINIA HOSPITAL FINANCE AUTHORITY ACT.

§16-29A-20. Certificate of need.

[Repealed.]

ARTICLE 29B. HEALTH CARE AUTHORITY.

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

~~The Legislature hereby finds that the health and welfare of the citizens of this state is being threatened by unreasonable increases in the cost of health care services, a fragmented system of health care, lack of integration and coordination of health care services, unequal access to primary and preventative care, lack of a comprehensive and coordinated health information system to~~

~~gather and disseminate data to promote the availability of cost-effective, high-quality services and to permit effective health planning and analysis of utilization, clinical outcomes and cost and risk factors. In order to alleviate these threats: (1) Information on health care costs must be gathered; and (2) an entity of state government must be given authority to ensure the containment of health care costs, to gather and disseminate health care information; to analyze and report on changes in the health care delivery system as a result of evolving market forces, and to assure that the state health plan, certificate of need program, and information systems serve to promote cost containment, access to care, quality of services and prevention. Therefore, the purpose of this article is to protect the health and well-being of the citizens of this state by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective, high-quality health care services.~~

(a) On January 1, 2027, the authority shall be terminated, and all of its records, assets, and equipment shall be transferred to the department of health;

(b) On that day, all of the authority's employment positions shall be abolished. The Secretary of the Department of Health may hire any employee of the authority to fill vacant positions within the department: *Provided*, that any person hired pursuant to this subsection is hired in the classified-exempt service system as defined in §29-6-2(g) of this code.

§16-29B-2. Effective Date.

[Repealed.]

§16-29B-3. Definitions.

~~(a) Definitions of words and terms defined in article two-d of this chapter are incorporated in this section unless this section has different definitions.~~

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

~~(1)~~ "Authority" means the Health Care Authority created pursuant to the provisions of this article;

~~(2) "Board" means the five-member board of directors of the West Virginia Health Care~~

~~Authority;~~

~~(3) "Charges" means the economic value established for accounting purposes of the goods and services a hospital provides for all classes of purchasers;~~

~~(4) "Class of purchaser" means a group of potential hospital patients with common characteristics affecting the way in which their hospital care is financed. Examples of classes of purchasers are Medicare beneficiaries, welfare recipients, subscribers of corporations established and operated pursuant to article twenty-four, chapter thirty-three of this code, members of health maintenance organizations and other groups as defined by the authority;~~

~~(5)~~ "Covered facility" means a hospital, behavioral health facility, kidney disease treatment center, including a free-standing hemodialysis unit; ambulatory health care facility; ambulatory surgical facility; home health agency; rehabilitation facility; or community mental health or intellectual disability facility, whether under public or private ownership or as a profit or nonprofit organization and whether or not licensed or required to be licensed, in whole or in part, by the state: *Provided*, That nonprofit, community-based primary care centers providing primary care services without regard to ability to pay which provide the Secretary with a year-end audited financial statement prepared in accordance with generally accepted auditing standards and with governmental auditing standards issued by the Comptroller General of the United States shall be deemed to have complied with the disclosure requirements of this section.

~~(6) "Executive Director" or "Director" means the administrative head of the Health Care Authority as set forth in section five-a of this article;~~

~~(7)~~ "Health care provider" means a person, partnership, corporation, facility, hospital or institution licensed, certified or authorized by law to provide professional health care service in this state to an individual during this individual's medical, remedial, or behavioral health care, treatment or confinement~~. For purposes of this article, "health care provider" shall not include the private office practice of one or more health care professionals licensed to practice in this state pursuant to the provisions of chapter thirty of this code~~;

~~(8)~~ "Hospital" means a facility subject to licensure as such under the provisions of article five-b of this chapter, and any acute care facility operated by the state government which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, and does not include state mental health facilities or state long-term care facilities; and

~~(9) "Person" means an individual, trust, estate, partnership, committee, corporation, association or other organization such as a joint stock company, a state or political subdivision or instrumentality thereof or any legal entity recognized by the state;~~

~~(10) "Purchaser" means a consumer of patient care services, a natural person who is directly or indirectly responsible for payment for such patient care services rendered by a health care provider, but does not include third-party payers;~~

~~(11) "Rates" means all value given or money payable to health care providers for health care services, including fees, charges and cost reimbursements;~~

~~(12) "Records" means accounts, books and other data related to health care costs at health care facilities subject to the provisions of this article which do not include privileged medical information, individual personal data, confidential information, the disclosure of which is prohibited by other provisions of this code and the laws enacted by the federal government, and information, the disclosure of which would be an invasion of privacy;~~

~~(13) "Related organization" means an organization, whether publicly owned, nonprofit, tax-exempt or for profit, related to a health care provider through common membership, governing bodies, trustees, officers, stock ownership, family members, partners or limited partners including, but not limited to, subsidiaries, foundations, related corporations and joint ventures. For the purposes of this subsection family members means brothers and sisters, whether by the whole or half blood, spouse, ancestors and lineal descendants;~~

~~(14)~~ "Secretary" means the Secretary of the Department of Health~~; and~~ .

~~(15) "Third-party payor" means any natural person, person, corporation or government~~

~~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.

[Repealed.]

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

[Repealed.]

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

~~The authority may:~~

~~(1) In cooperation with the secretary, propose legislative rules in accordance with §29A-3-1 *et seq*. of this code;~~

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

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

The secretary shall propose a repeal, pursuant to either §29A-3-1a(b) or §29A-3-8(c) of the code, as appropriate, of any rule promulgated by the authority pursuant to this section to be considered by the Legislature during the 2027 regular session of the Legislature.

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

[Repealed.]

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

[Repealed.]

§16-29B-14. Injunction; mandamus.

[Repealed.]

§16-29B-15. Refusal to comply.

[Repealed.]

§16-29B-24. Reports required to be filed; and legislative rulemaking regarding uniform bill database.

[Repealed.]

§16-29B-25. Data repository.

(a) The ~~authority~~ secretary shall:

(1) Coordinate and oversee the health data collection of state agencies;

(2) Lead state agencies' efforts to make the best use of emerging technology to affect the expedient and appropriate exchange of health care information and data, including patient records and reports; and

(3) Coordinate database development, analysis, and report to facilitate cost management, review utilization review and quality assurance efforts by state payor and regulatory agencies, insurers, consumers, providers, and other interested parties.

(b) A state agency collecting health data shall work through the ~~authority~~ secretary to develop an integrated system for the efficient collection, responsible use, and dissemination of data and to facilitate and support the development of statewide health information systems that will allow for the electronic transmittal of all health information and claims processing activities of a state agency within the state, and to coordinate the development and use of electronic health information systems within state government.

(c) The ~~authority~~ secretary shall establish minimum requirements and issue reports relating to information systems of state health programs, including simplifying and standardizing forms and establishing information standards and reports for capitated managed care programs.

(d) The ~~authority~~ secretary shall develop a comprehensive system to collect ambulatory

health care data.

(e) The ~~authority~~ secretary may access any health-related database maintained or operated by a state agency for the purposes of fulfilling its duties. The use and dissemination of information from that database shall be subject to the confidentiality provisions applicable to that database.

(f) A report, statement, schedule, or other filing may not contain any medical or individual information personally identifiable to a patient or a consumer of health services, whether directly or indirectly.

(g) A report, statement, schedule, or other filing filed with the authority is open to public inspection and examination during regular hours. A copy shall be made available to the public upon request upon payment of a fee.

(h) The ~~authority~~ secretary may require the production of any records necessary to verify the accuracy of any information set forth in any statement, schedule, or report filed under the provisions of this article.

(i) The ~~authority~~ secretary may provide requested aggregate data to an entity. The ~~authority~~ secretary may charge a fee to an entity to obtain the data collected by the ~~authority~~ secretary. The ~~authority~~ secretary may not charge a fee to a covered entity to obtain the data collected by the ~~authority~~ secretary.

(j) The ~~authority~~ secretary shall provide to the Legislative Oversight Commission on Health and Human Resources Accountability before July 1, ~~2018~~ 2025, and every other year thereafter, a strategic data collection and analysis plan:

(1) What entities are submitting data;

(2) What data is being collected;

(3) The types of analysis performed on the submitted data;

(4) A way to reduce duplicative data submissions; and

(5) The current and projected expenses to operate the data collection and analysis

program.

(k) ~~The Secretary of the Department of Health~~ The secretary may ~~assume the powers and duties provided to the authority in this section, if the secretary determines it is more efficient and cost effective to have direct control over the data repository program. To the extent that the secretary assumes the powers and duties in this section, the secretary shall inform the Legislative Oversight Commission on Health and Human Resources Accountability by July 1 of each year, regarding each program for which he or she is exercising such authority and shall~~ propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code to effectuate the directives of this section. ~~within the time limit to be considered by the Legislature during its next regular session. In the event the secretary has already assumed the powers and duties provided to the authority in this section, the secretary shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code within the time limit to be considered by the Legislature during the regular session of the Legislature, 2023~~.

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

~~(a) Actions of the authority shall be exempt from antitrust action under state and federal antitrust laws.~~ Any action~~s~~ of hospitals and health care providers taken under the authority's jurisdiction prior to January 1, 2027, shall be exempt from state and federal antitrust laws if that action was taken ~~when made~~ in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the authority~~, shall likewise be exempt~~.

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

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

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

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

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

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

~~(4) "Commercial health plan" means a plan offered by any third party payor that negotiates with a party to a cooperative agreement with respect to patient care services rendered by health care providers.~~

~~(5)~~ "Health care provider" means the same as that term is defined in section three of this article.

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

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

(b) On January 1, 2027, the process for reviewing cooperative agreements pursuant to this section shall be abolished. Any cooperative agreement~~s~~ approved by the authority under this section prior to January 1, 2027, and activities conducted pursuant thereto shall be exempt from state and federal antitrust laws.

~~(b) *Findings.*~~

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

~~(2) A medical education is enhanced when medical students, residents and fellows have access to modern facilities, state of the art equipment and a full range of clinical services and that, in many instances, the accessibility to facilities, equipment and clinical services can be achieved more economically and efficiently through a cooperative agreement among a qualified hospital and one or more hospitals or other health care providers.~~

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

~~(d) *Cooperative Agreements.* —~~

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

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

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

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

~~(A) Improve access to care;~~

~~(B) Advance health status;~~

~~(C) Target regional health issues;~~

~~(D) Promote technological advancement;~~

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

~~(F) Enhance academic engagement in regional health;~~

~~(G) Preserve and improve medical education opportunities;~~

~~(H) Strengthen the workforce for health-related careers; and~~

~~(I) Improve health entity collaboration and regional integration, where appropriate.~~

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

~~(A) Population health improvement;~~

~~(B) Improved access to health care services;~~

~~(C) Improved quality;~~

~~(D) Cost efficiencies;~~

~~(E) Ensuring affordability of care;~~

~~(F) Enhancing and preserving medical education programs; and~~

~~(G) Supporting the authority's goals and strategic mission, as applicable.~~

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

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

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

~~(e) *Procedure for review of cooperative agreements.*~~

~~(1) Upon receipt of an application, the authority shall determine whether the application is complete. If the authority determines the application is incomplete, it shall notify the applicant in writing of additional items required to complete the application. A copy of the complete application shall be provided by the parties to the Office of the Attorney General simultaneous with the submission to the authority. If an applicant believes the materials submitted contain proprietary information that is required to remain confidential, such information must be clearly identified and the applicant shall submit duplicate applications, one with full information for the authority's use and one redacted application available for release to the public.~~

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

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

~~(ii) Deny the application; or~~

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

~~(3) The authority shall issue a written decision within seventy-five days from receipt of the~~

~~completed application. The authority may request additional information in which case they shall have an additional fifteen days following receipt of the supplemental information to approve or deny the proposed cooperative agreement.~~

~~(4) Notice of any hearing shall be sent by certified mail to the applicants and all persons, groups or organizations who have submitted written comments on the proposed cooperative agreement. Any individual, group or organization who submitted written comments regarding the application and wishes to present evidence at the public hearing shall request to be recognized as an affected party as set forth in article two-d of this chapter. The hearing shall be held no later than forty-five days after receipt of the application. The authority shall publish notice of the hearing on the authority's website fifteen days prior to the hearing. The authority shall additionally provide timely notice of such hearing in the State Register.~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(G) Avoidance of duplication of hospital resources;~~

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

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

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

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

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

~~(C) The extent of any likely adverse impact on patients in the quality, availability and price~~

~~of health care services; and~~

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

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

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

~~(i) Achieving improvements in population health;~~

~~(ii) Access to health care services;~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(B) If an approved application involves the combination of hospitals, disclosure of the performance of each hospital with respect to a representative sample of quality metrics selected annually by the authority from the most recent quality metrics published by the Centers for~~

~~Medicare and Medicaid Services. The representative sample shall be published by the authority on its website.~~

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

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

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

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

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

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

~~(i) The parties to the agreement are not complying with the terms of the agreement or the~~

~~terms and conditions of approval;~~

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

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

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

~~(G) If the authority determines the parties to an approved cooperative agreement have engaged in conduct that is contrary to state policy or the public interest, including the failure to take action required by state policy or the public interest, the authority may initiate a proceeding to determine whether to require the parties to refrain from taking such action or requiring the parties to take such action, regardless of whether or not the benefits of the cooperative agreement continue to outweigh its disadvantages. Any determination by the authority shall be final. The authority is specifically authorized to enforce its determination in the circuit court of Kanawha County or the circuit court where the principal place of business of a party to the cooperative agreement is located.~~

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

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

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

(i) *Miscellaneous provisions. —*

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

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

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

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

~~(4) No hospital which is a party to a cooperative agreement for which approval is required pursuant to this section may knowingly bill or charge for health services resulting from, or associated with, such cooperative agreement until approved by the authority. Additionally, no hospital which is a party to a cooperative agreement may knowingly bill or charge for health services resulting from, or associated with, such cooperative agreement for which approval has been revoked or terminated.~~

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

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

[Repealed.]

§16-29B-31. Hospice need standard review; membership; report to the Legislative Oversight Committee on Health and Human Resources.

[Repealed.]

CHAPTER 16B. INSPECTOR GENERAL.

ARTICLE 13. MEDICATION-ASSISTED TREATMENT PROGRAM LICENSING ACT.

§16B-13-12. Moratorium; certificate of need.

[Repealed.]

ARTICLE 21. NEONATAL ABSTINENCE SYNDRONE CENTER.

§16B-21-3. Certificate of need; exemption from moratorium.

[Repealed.]

CHAPTER 33. INSURANCE.

ARTICLE 15B. UNIFORM HEALTH CARE ADMINISTRATION ACT.

§33-15B-5. Penalties for violation.

Any person, partnership, corporation, limited liability company, professional corporation, health care provider, insurer or other payer, or other entity violating any provision of this article shall be subject to a fine imposed by the commissioner of not more than $1000 for each violation ~~and, in addition to or in lieu of any fine imposed, the West Virginia health care authority is empowered to withhold rate approval or a certificate of need for any health care provider violating any provision of this article~~.

CHAPTER 49. CHILD WELFARE.

ARTICLE 2. STATE RESPONSIBILITIES FOR CHILDREN.

§49-2-124. Certificate of need not required; conditions; review.

[Repealed.]

CHAPTER 51. COURTS AND THEIR OFFICERS.

ARTICLE 11. THE WEST VIRGINIA APPELLATE REORGANIZATION ACT.

§51-11-4. Jurisdiction; limitations.

(a) The Intermediate Court of Appeals has no original jurisdiction.

(b) Unless specifically provided otherwise in this article, appeals of the following matters shall be made to the Intermediate Court of Appeals, which has appellate jurisdiction over such matters:

(1) Final judgments or orders of a circuit court in all civil cases, including, but not limited to, those in which there is a request for legal or equitable relief, entered after June 30, 2022: *Provided*, That the Supreme Court of Appeals may, on its own accord, obtain jurisdiction over any civil case filed in the Intermediate Court of Appeals;

(2) Final judgments or orders of a family court, entered after June 30, 2022, except for final judgments or final orders issued by a family court in any domestic violence proceeding pursuant to W. Va. Code §48-27-1 *et seq*. of this code, which appeals shall first be made to a circuit court;

(3) Final judgments or orders of a circuit court concerning guardianship or conservatorship matters entered after June 30, 2022, pursuant to §44A-1-1 *et seq*. of this code;

(4) Final judgments, orders, or decisions of an agency or an administrative law judge entered after June 30, 2022, heretofore appealable to the Circuit Court of Kanawha County pursuant to §29A-5-4 or any other provision of this code;

(5) Final orders or decisions of the Health Care Authority issued prior to June 30, 2022, in a certificate of need review, but transferred to the jurisdiction of the Intermediate Court of Appeals upon termination of the Office of Judges pursuant to §16-2D-16a of this code <u>except that after January 1, 2027, no health care facility or covered facility may be required to obtain a certificate of need pursuant to §16-2D-1 *et seq*. of this code;</u>

(6) Final orders or decisions issued by the Office of Judges after June 30, 2022, and prior to its termination, as provided in §16-2D-16 and §23-5-8a of this code; and

(7) Final orders or decisions of the Workers' Compensation Board of Review pursuant to §23-5-1 *et seq*. of this code, entered after June 30, 2022.

(c) In appeals properly filed pursuant to subsection (b) of this section, the parties shall be afforded a full and meaningful review on the record of the lower tribunal and an opportunity to be heard.

(d) The Intermediate Court of Appeals does not have appellate jurisdiction over the following matters:

(1) Judgments or final orders issued in any criminal proceeding in this state: *Provided*, That if the West Virginia Supreme Court of Appeals should adopt a policy of discretionary review of criminal appeals, then the Intermediate Court of Appeals shall have appellate jurisdiction of such judgments or final orders;

(2) Judgments or final orders issued in any juvenile proceeding pursuant to §49-4-701 *et seq*. of this code;

(3) Judgments or final orders issued in child abuse and neglect proceedings pursuant to §49-4-601 *et seq*. of this code;

(4) Orders of commitment, issued pursuant to §27-5-1 *et seq*. of this code;

(5) Any proceedings of the Lawyer Disciplinary Board;

(6) Any proceedings of the Judicial Investigation Commission;

(7) Final decisions of the Public Service Commission, issued pursuant to §24-5-1 of this code;

(8) Interlocutory appeals;

(9) Certified questions of law;

(10) Judgments or final orders issued in proceedings where the relief sought is one or more of the following extraordinary remedies: writ of prohibition, writ of mandamus, writ of quo warranto, writ of certiorari, writ of habeas corpus, special receivers, arrests in civil cases, and personal safety orders; and

(11) Judgments or final orders issued by circuit court upon its review of a family court judgment or final order in any domestic violence proceeding pursuant to §48-27-101 *et seq*. of this code.

NOTE: The purpose of this bill is to terminate the West Virginia Health Care Authority; terminate the authority's certificate of need program; providing the termination of the authority's cooperative agreement review process; provide definitions; establishing when the secretary shall propose a repeal; clarify the transfer of the authority's remaining powers, assets, records, and employees to the Secretary of the Department of Health; clarify the money to be transferred to the general revenue fund; and establish exemptions.

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