LEGISLATIVE AUDIT REPORT

HEALTH CARE AUTHORITY

Certificate of Need

AUDIT PERIOD 2011 - 2015

FINDINGS

- The West Virginia Health Care Authority's Certificate of Need Program is an Ineffective and Unnecessary Regulatory Function

WEST VIRGINIA LEGISLATIVE AUDITOR

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A REPORT TO THE WEST VIRGINIA LEGISLATURE
February 7, 2017

HEALTH CARE AUTHORITY
Certificate of Need

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Issue 1: The West Virginia Health Care Authority's Certificate of Need Program is an Ineffective and Unnecessary Regulatory Function.

Introduction

Following the 2016 Legislative Session, the Legislative Auditor directed his staff to conduct an audit of the West Virginia Health Care Authority (Authority). The objective of this audit was to analyze the necessity and efficiency of the operations of the Authority and its primary sectors, including Certificate of Need. The Legislative Auditor's examination of the agency's Certificate of Need (CON) program finds the following:

1. West Virginia's per capita health care costs have grown at the 7th fastest rate in the U.S., when compared to other states, and ranks 12th overall at $7,667 in 2009.
2. The Authority's CON program issued a decision on 228 CON applications between 2011 and 2015. Over this period, only four applications were denied a CON—a 98 percent approval rate.
3. The federal government has designated over 220 areas in West Virginia as having a shortage of primary care and mental health services, including 40 whole counties. Additionally, 53 of the State's 55 counties are designated as Medically Underserved Areas/Populations.

Therefore, the Legislative Auditor concludes that West Virginia's CON program is ineffective in restraining health care costs, and is an unnecessary regulatory burden to providers of health care services in West Virginia. **The Legislative Auditor recommends that the Legislature should consider repealing West Virginia's Certificate of Need Law.**

Certificate of Need Laws Originate from a Congressional Mandate Aimed at Controlling the Increases in Health Care Cost.

Certificate of Need (CON) laws are state-level regulatory initiatives that require health care providers to obtain permission from a state health planning agency prior to making any significant capital expenditure, initiating new construction, expanding facilities or services, or purchasing new medical equipment.

Congress' passage of the National Health Planning and Resources Development Act of 1974 (NHPRDA) required all 50 states to establish CON laws. The Congressional mandate for states to establish CON laws had a singular purpose: control the increase in the costs of the nation's health care. In 1987, Congress repealed the NHPRDA, eliminating federal funding for state health planning agencies and leaving states free to repeal their own CON laws. Since the NHPRDA was repealed, 15 states have eliminated their CON laws. Currently, 35 states and the District of Columbia, including West Virginia, have some form of CON law. The map in Appendix D shows the breakdown of states with and without CON laws.

West Virginia's Certificate of Need Program

The West Virginia Health Care Authority (Authority) administers West Virginia's CON program. The primary goals of West Virginia's CON law are to restrain the increases in health care costs and ensure that the development of new health care services are needed. W. Va. Code 16-2D-1, establishing the State's CON law, declares:

> *That the offering or development of 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 the increases in the cost of delivering health services.*** (Emphasis added)

During the 2016 regular session, the Legislature passed major modifications to the CON process. The process begins with a health care provider or potential new health care provider filing a letter of intent with the Authority, indicating its intention to provide new or expanded health care services that require a CON. In addition, the applicant is required to submit the appropriate application fee along with the letter of intent. W. Va. Code establishes CON application fees based upon the application type and the associated capital expenditure as shown in Table 1.

Table 1
Certificate of Need Application Fees

Application Type	Associated Capital Expenditure	Application Fee
Exemption Application	$0*	$1,000
Regular Application	$0-1,500,000	$1,500
	$1,500,001-5,000,000	$5,000
	$5,000,001-25,000,000	$25,000
	25,000,001 and above	$35,000

Source: West Virginia. Code 16-2D, as amended during the 2016 Regular Session.
**An application for an exemption to CON requires a $1,000 application fee regardless of the associated capital expenditure.*

The application fees collected by the Authority are deposited into a special revenue account, which funds the operations of the CON program. As of February 2017, the CON fund has a balance of approximately $2 million.

While Code establishes a timeline for CON reviews, the amount of time to complete the CON application process varies based upon whether the application is contested by an affected party. The process could subject a provider to a wait of up to 95 days for an uncontested

application, or up to 220 days for a contested application. Tables 2 and 3 below reflect the respective timelines for an uncontested and contested CON application process.

Table 2 Timeline for Uncontested Certificate of Need Process	
Number of Days	**Regulatory Action**
0	File a letter of intent with the Health Care Authority (Authority)
10	File application for a Certificate of Need
20	Application is deemed complete by the Authority (up to 10 days)
35	Completed applications are batched on 15th and last days of each month (up to 15 days)
95	Authority decision date (application is deemed approved if review is not completed within 60 days from the date the application is batched.)
Maximum Time for Uncontested Review: Approximately 3 Months	
Source: West Virginia Code 16-2D-14	

Table 3 Timeline for Contested Certificate of Need Process	
Number of Days	**Regulatory Action**
0	File a letter of intent with the Health Care Authority (Authority)
10	File application for a Certificate of Need
20	Application is deemed complete by the Authority (up to 10 days)
35	Completed applications are batched on 15th and last days of each month (up to 15 days)
65	Window for affected party to request a hearing (30 days from batching)
70	Close-date for affected parties—no further evidence received
85	Request for a hearing approved by Authority
175	Hearing date (up to 3 months from date request approved)
220	Authority decision date (final review period: 45 days)
Maximum Time for Regular Review with a Hearing: Approximately 7 Months	
Source: West Virginia Code 16-2D-13	

Despite significant changes to the CON application process during the 2016 Regular Session, an applicant for a CON can still be delayed from providing new or expanded health care services for as many as seven months while the Authority reviews the application. In addition, applicants whose CON applications are denied **or an affected person,** as defined within the article, may request an appeal. Appeal hearings are handled by the Office of Judges within the Insurance Commission, and may add an additional three-to-four months to the CON process. Table 4 shows the statutory timeline for appealing a CON denial. Finally, Code provides that a final decision entered by the Office of Judges may be appealed in the Kanawha County Circuit Court by the applicant of a denied CON, or any affected person.

Table 4 Timeline for Appeal of a Denied Certificate of Need	
Number of Day	**Regulatory Action**
0	Authority denies an application for a Certificate of Need
30	Appeal requested (up to 30 days from the date of the Authority's decision)
60	Appeal hearing (up to 30 days from the date the appeal was requested)
105	Office of Judges decision date (final review period: 45 days)
Maximum Time for Appeal: Approximately 3.5 Months	
Source: West Virginia Code 16-2D-16	

West Virginia's Certificate of Need Program is One of the Most Extensive CON Laws in the United States.

The Legislative Auditor finds that while 35 states have some form of CON law, these laws vary significantly in the scope of services covered. W. Va. Code 16-2D-8 establishes the proposed health care services that require a CON before the services may be provided or developed. Figure 1 depicts the number of services included in each state's CON law. According to the Mercatus Center at George Mason University, West Virginia's CON law is tied for the 6th most extensive law in the U.S., requiring a CON for 23 different proposed health care services. The table in Appendix E of this report provides a detailed look at the individual health services covered by each state's CON law.

Figure 1

Source: Compiled from state laws, current regulatory documents, agency forms, and direct communication with regulators in each state.
Produced by Christopher Koopman, Anne Philpot, and Gregory Burns, September 27, 2016.

The State's Certificate of Need Program Has Not Been Effective in Restraining the Increases in the Costs of Health Care.

The Director of West Virginia's CON program indicated to the Legislative Auditor that the Authority assesses and measures the success of the program in meeting its goal of restraining the growth in healthcare costs by comparing the State's costs with the rest of the U.S. However, he stated that it's difficult to fully measure the program's cost-saving effect and attributes cost savings to a deterrence effect—the idea that some potential applicants who would otherwise seek a CON for unnecessary health services are deterred from applying due to the time, costs, and likelihood of being denied. Therefore, the Legislative Auditor's current review measures the program's effectiveness by comparing the State's healthcare costs with the rest of the U.S.

In a May 1996 performance review of the Authority, the Legislative Auditor looked at West Virginia's **total** average annual growth in spending for hospital care, physician services, and prescription drugs, and found that the State's total spending ranked 46th out of the 50 states. The report concluded that, *"[The Performance Evaluation and Research Division] was unable to determine whether this is due to the actions of the [Authority], but the data appears to demonstrate the possible effectiveness of the agency."*

In the present review, the Legislative Auditor examined West Virginia's average annual growth rate for **per capita** healthcare spending. An analysis of per capita healthcare spending controls for the variance in population across the 50 U.S. states. According to data compiled by the U.S. Census Bureau and the federal Centers for Medicare and Medicaid Services, West Virginia's per capita spending on personal health care grew at an average annual rate of 6.2 percent between 1991 and 2009.

As Table 5 below demonstrates, West Virginia's per capita spending on total health care has grown at one of the fastest rates in the U.S. between 1991 and 2009. West Virginia's annual average growth rate in hospital care, physician services, and nursing home care all exceed the average growth rate for those services nationally. In addition, West Virginia's per capita spending on total personal care ranks as the 12th highest in the U.S., at $7,667 per capita, and its per capita spending on hospital care ranks 10th.

Table 5
Average Annual Growth in Per Capita Health Care Spending
1991-2009

	Hospital Care	Physician Services	Home Health Care	Nursing Home Care	Total Personal Health Care	Total Personal Health Care Rank
West Virginia	5.5%	5.6%	7.4%	6.1%	6.2%	7th
U.S.	4.7%	4.9%	7.6%	4.7%	5.3%	-

Source: U.S. Census Bureau and CMS, Office of the Actuary data.

West Virginia's Certificate of Need Program Has Not Been an Effective and Necessary Determinant of Need.

The Legislative Auditor also measured the CON program's performance against its goal of ensuring that the development of new health services meets an established need. This analysis looks at the decisions rendered by the Authority between 2011 and 2015 for two different types of applications filed by an applicant: reviewability requests and applications for a CON.

Prior to starting the CON application process, a provider or potential provider of a proposed health service may make a written request to the Authority for it to determine whether a proposed health service is subject to the CON review process. Statute establishes that this process is voluntary, and any person seeking a determination of reviewability must pay a $100 fee to the Authority.

The Legislative Auditor accessed decision files for all reviewability determinations from 2011 to 2015 from the Authority's website. The Authority issued a decision in 769 reviewability requests over this time period. As Table 6 shows, over the 5-year scope of the audit, the Authority determined that only 64 reviewability requests (8 percent) were subject to a CON review. It was determined by the Authority that more than 92 percent of the potential health care providers did not require a CON in order to provide their proposed health services.

Table 6
Reviewability Determinations by the West Virginia Health Care Authority
2011-2015

	2015	2014	2013	2012	2011	Total
Subject to Review	9	9	16	18	12	64
Not Subject to Review	137	140	160	126	142	705

Source: Legislative Auditor's review of the Authority's decision files, accessed through its online document archives.

The Legislative Auditor also accessed the Authority's decision files for CON applications. From 2011 to 2015, the Authority issued a decision on 228 applications for a CON. The Legislative Auditor finds that the Authority has only denied four applications[1] for a CON over the five-year scope of this review—an effective approval rate of over 98 percent. Table 7 provides a breakdown by year.

Table 7
Decisions for CON Applications by the West Virginia Health Care Authority
2011-2015

	2015	2014	2013	2012	2011	Total
Approved	50	54	42	45	33	224
Denied	2	0	1	0	1	4

Source: Legislative Auditor's review of the Authority's decision files, accessed through its online document archives.

[1] The denied applications were for the purchase of a new MRI, a hospital merger, establishment of a 10-station dialysis unit, and the provision of in-home personal care.

Given the State's high per capita spending on health care services and the near-universal approval of CON applications by the Authority, the Legislative Auditor concludes that West Virginia's CON program is ineffective and an unnecessary bureaucratic process.

Empirical Evidence Suggests That Certificate of Need Laws Have No Effect On Health Care Costs

The Legislative Auditor compared the average per capita health care costs between states that have CON laws and the states without. Table 8 below shows the differences in the average per capita cost in hospital care, nursing home care, and total personal health care spending for 2009. While the per capita costs are lower in the 15 states without CON, they do not appear to be significantly lower than the costs in states with an active CON program.

Table 8
Comparison in Average in Per Capita Spending
Between States With CON and States Without

	Hospital Care	Nursing Home Care	Personal Health Care
States with CON	$2,725	$479	$7,163
States without CON	$2,554	$440	$6,733

Source: U.S. Census Bureau and CMS, Office of the Actuary data for 2009.

In addition, the Legislative Auditor used these same data to determine whether any relationship exists between a state having a CON program and its per capita spending on personal health care services by calculating a correlation coefficient between the two variables. The correlation analysis shown in Table 9 below shows a correlation coefficient of 0.19. A correlation coefficient close to zero indicates a weak or no linear relationship between having a CON program and the cost of health care per capita.

Table 9
Pearson's Correlation Coefficient

	Personal Health Care	*CON*
Personal Health Care	1	
CON	0.189830946	1

The results of these analyses are in line with the empirical research on the effects of CON laws on health care costs. In 2007, the U.S. Division of Justice's Antitrust Division stated, "*The empirical evidence on the economic effect of CON programs demonstrated near-universal agreement among health economists that CON laws were unsuccessful in constraining health care costs.*" Similarly, the Washington Joint Legislative Audit and Review Committee found in 1999 that, "*The weight of findings* ***over the last three decades*** *is that CON laws have had little or no effect in controlling general health care expenditures or hospital costs.*" (Emphasis added).

The U. S. Department of Health and Human Services Has Designated 53 of West Virginia's 55 Counties as Having a High Amount of Unmet Need.

The Legislative Auditor reviewed the Health Resources and Service Administration's database for Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P) in West Virginia. The federal government designates HPSAs and MUA/P areas to indicate that an area has a significant need of resources and providers in primary care, dental health, or mental health. Provider shortages may be designated by geographic area, population, or facility. To be classified as a HPSA or MUA/P in West Virginia, the Division of Primary Care within the West Virginia Department of Health and Human Resources must submit an application to the Health Resources and Service Administration.

The Legislative Auditor's review of these data find that, 53 of West Virginia's 55 counties have at least one area designated as an HPSA for primary care and mental health services, **including 40 whole counties.** In addition, 53 counties are designated as MUA/Ps, in part or in whole. Certification of need through the CON process is redundant and unnecessary considering nearly the entire state has already been designated as having shortages or underserved areas and populations.

Conclusion

The Legislative Auditor concludes that West Virginia's CON program is both ineffective as a cost control mechanism and an unnecessary barrier to entry into a health care market place that is inundated with unmet need.

The U.S. Department of Justice's Antitrust Division and the Federal Trade Commission stated in a joint report that, "*CON programs are not successful in containing health care costs, and . . . they pose serious anticompetitive risks that usually outweigh their purported economic benefits.*" The Legislative Auditor's review of West Virginia's CON law is consistent with this and other academic literature on CON programs in finding no demonstrable impact in restraining the costs of health care. While the Authority may point to some unquantifiable savings as a result of a deterrence effect, the Legislative Auditor is not convinced that any potential providers of health care services would be deterred by a 98 percent approval rate.

Over the scope of this review, the Legislative Auditor finds that the CON process has cost providers and potential providers an estimated $2.3 million in application fees, and an average of three-and-a-half months per application. Meanwhile, the growth in the per capita cost of health care services in West Virginia continues to exceed the national average and rank among the highest rates in the U.S.

Further, it is the opinion of the Legislative Auditor that West Virginia's high levels of need for health care providers and services is reflected not only in the number of Health Provider Shortage Areas and Medically Underserved Areas or Populations, but in the Authority's near-universal approval of CON applications. The State's aging population is likely to exacerbate these

needs going forward. **Therefore, the Legislative Auditor recommends that the Legislature consider repealing West Virginia's Certificate of Need Law.**

Issue 2: If the Legislature Repeals the Certificate of Need Process, the Legislative Auditor Suggests a Restructuring of the Health Care Authority and Its Remaining Functions.

Introduction

The Legislature created the Health Care Authority (HCA) as an autonomous state agency in 1983 and established three primary functions for the agency:

1. Rate review for hospitals,
2. Administering Certificate of Need, and
3. Carrying out the requirements of the Financial Disclosures Act in W. Va. Code §16-5F.

The Financial Analysis Division carries out the requirements of the Financial Disclosures Act. Since the Health Care Authority's creation, four additional divisions/programs have been added and are currently still operating:

1. Clinical Analysis Division
2. Rural Health Systems Program (RHSP)
3. State Privacy Office
4. West Virginia Health Information Network (WVHIN).

The four programs and the Financial Analysis Division are operated by approximately 30 staff. The distribution of staff for these sections is outlined in Table 1 below. These five sections operate from two appropriated special revenue accounts totaling $6.3 million.

Table 1
Distribution of Staff

Section	Number of Employees
Financial Analysis Division	8
Clinical Analysis Division	2
Rural Health Systems Program	9
State Privacy Office	3
West Virginia Health Information Network	4

Source: Authority's Organizational Chart and Staff Directory listing

The Legislature removed the rate review for hospitals function from the Authority during the 2016 Legislative Session. Further, if the Legislature repeals the State's CON law, as recommended in Issue 1, the Legislative Auditor finds it necessary to evaluate whether the Authority should continue to operate as an independent state agency overseen by three Authority members. It should also be evaluated whether the remaining functions should be continued, and if so, should those functions be relocated within state government.

The Financial and Clinical Analysis Divisions Collect and Publish Data, But the Legislative Auditor Is Unable to Determine Its Value and Use.

The Authority operates two data analysis units. The Financial Analysis Division is responsible for executing the requirements of the Financial Disclosures Act in W. Va. Code §16-5F, and operates with eight staff members who collect and process financial data from approximately 450 healthcare providers annually. The Division's staff log these data into a database to track compliance with W. Va. Code, review submissions for accuracy, and redact all personal identification information.

Once collected, these data are uploaded into a publically accessible database for use by the public and in various projects, such as custom data requests, the Authority's annual report, and supporting the Authority's CON program. However, the Authority indicated to the Legislative Auditor that its current online database does not track user-traffic, so it is difficult to measure the use of the data.

The Clinical Analysis Division operates with two staff members who collect and analyze inpatient uniform billing data. These data are used by the Division's staff to assess utilization, access, costs, and quality of healthcare services. The data collected by the Clinical Analysis Division is largely disseminated through custom data requests and standard reports published by the Authority. According to the Authority's data request log for 2014 and 2015, the Clinical Analysis Division fills about 30 requests per year, largely for research institutions, national associations, or hospitals and health care consulting groups to aid in the CON application process. Appendix F provides a list of these requests. **The Legislative Auditor is unable to determine how much of the data collected, analyzed, and published by the Authority's Financial and Clinical Analysis Divisions are used. Thus, is unable to determine its value.** Therefore, the Legislature should determine whether this function should continue. If it is continued, and the Legislature determines to repeal Certificate of Need, the Legislative Auditor suggests that it be relocated to another section within the Department of Health and Human Resources.

Between 2011 and 2015, the Health Care Authority's Rural Health Systems Program Provided $3.3 Million in Grants to Hospitals and Providers.

The Authority operates the Rural Health Systems Program which distributes state funds for collaborative grants and crisis grants. Collaborative grants are projects in which two or more health care providers collaborate to provide a service. Crisis grants fund projects for emergency or essential items needed when health services or patient care are at risk. Health care providers apply for crisis grants when facing potential foreclosure from having severe financial difficulties due to cash flow problems, extreme growth in accounts receivable and payable, or multiple missed principle payments on long-term debt, etc. The Authority also awards other hospital assistance grants

If approved, grants are disbursed in accordance to the terms of the grantee's grant agreement which may be either monthly or quarterly, or on a schedule of payments, generally

when the grantee does not have sufficient cash on hand to pay for the grant expenditures before they are reimbursed. Eligible applicants which means a non-profit health care provider, health care facility or qualified government agency may apply for grants on an annual basis.

West Virginia Code §12-4-14 requires "persons" to file a report of expenditures with the Authority when receiving one or more state grants in the amount of fifty thousand dollars or more in the aggregate in a state's fiscal year. Any "person" who receives a state grant in an amount less than fifty thousand dollars is required to file a sworn statement of expenditures made under the grant. However, "persons," as defined by the article, includes any corporation, partnership, association, individual or legal entity, but does not include a state spending unit or a local government, making certain recipients exempt from filing.

The Legislative Auditor reviewed all grant awards issued by the Authority between 2011 to 2015. Over the scope of this review, the Authority distributed 59 grants for a total of $3,309,647. Table 2 below provides a breakdown of the total award amount for each grant type by year. The Authority awarded 25 crisis grants totaling $1,042,743, or 32 percent of the total grant expenditures.

Table 2
Grant Awards by Year
2011-2015

Type	2011	2012	2013	2014	2015	Total
Collaborative	$98,688	$250,000	$99,986	$210,020	$158,330	**$817,024**
Crisis	$187,000	$259,104	$261,639	$185,000	$150,000	**$1,042,743**
HAG	$78,994	$339,376	$289,710	$408,587	$333,213	**$1,449,880**
Total	**$364,682**	**$848,480**	**$651,335**	**$803,607**	**$641,543**	**$3,309,647**

Source: Legislative Auditor's calculations of agency-provided data

In addition, the Legislative Auditor determined that 18 grants (31 percent) were awarded to exempt agencies, defined as recipient who are not required to report their expenditures under W. Va. Code §12-4-14. As Table 3 shows, over $800,000 in state grants were awarded to exempt recipients between 2011 and 2015. Further, over 70 percent of exempt recipients received crisis grants, totaling $569,214.

Table 3 Grants Awarded to Exempt Recipients 2011-2015				
Year	**Collaborative**	**Crisis**	**HAG**	**Total**
2011	-	$137,000	-	$137,000
2012	$100,000	$110,000	-	$210,000
2013	-	$122,214	-	$122,214
2014	$99,368	$100,000	-	$199,368
2015	-	$100,000	$40,000	$140,000
Total	**$199,368**	**$569,214**	**$40,000**	**$808,582**
Source: Legislative Auditor's calculations of agency-provided data				

According to the Authority's documentation, ten exempt recipients filed a sworn statement of expenditures, despite not being required under W. Va. Code. In addition, the Authority provides oversight and accountability for all grants, regardless if the grantee is exempt from filing a sworn statement under W. Va. Code. However, to alleviate any inconsistencies in documentation or reporting for exempt entities, **the Legislative Auditor recommends that the Legislature should consider amending W.Va. Code §12-4-14 to provide for greater oversight and accountability of state grant monies awarded to state and local government entities.** Further, if the Legislature determines to continue the RHSP, the Legislative Auditor suggests that it be relocated to another section within the Department of Health and Human Resources.

The State Privacy Office and the West Virginia Health Information Network Operate with Minimal Administrative Support From the Health Care Authority

The State Privacy Office and the WVHIN were both established in 2006 and administratively housed within the Authority. The State Privacy Office was created under Executive Order 6-06 and operates with three administrative staff. Since its creation in 2006, the State Privacy Office has been tasked with protecting the privacy of all personally identifiable information that is collected or maintained by any and all Executive Branch agencies.

The Legislature established the WVHIN with the intent to:

> *promote the design, implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information in the state.*

The WVHIN is a public/private partnership which receives administrative support from the Authority, and works in close collaboration with a number of other entities, including the Department of Health and Human Resources, the Bureau for Medical Services, the Governor's Office of Health Enhancement and Lifestyle Planning, and the West Virginia Health Improvement Institute. Currently, the Authority supports the WVHIN with four staff members. If the

Legislature repeals the State's CON law, the Legislative Auditor suggests that the State Privacy Office be relocated to the Governor's Office, the Attorney General's Office, or another section within the Department of Health and Human Resources, and the WVHIN be transferred to the Office of Technology or another section within the Department of Health and Human Resources.

Conclusion

The Authority was established as an independent government agency to carry out three primary functions: rate review, CON, and financial disclosures. However, the Legislature eliminated rate review during the 2016 Legislative Session, and it is the opinion of the Legislative Auditor that CON is an unnecessary program and should likewise be eliminated.

While the Authority's remaining sections appear to provide necessary and high-quality work, it is unclear whether the remaining functions justify the Authority continuing to operate as an independent agency. The State Privacy Office and the WVHIN operate with minimal administrative support from the Authority and work collaboratively across state government and private industry. If the Legislature repeals the State's CON program, **the Legislative Auditor recommends that the Legislature evaluate whether the Authority should continue to operate as an independent state agency, and if certain functions can be relocated within state government or eliminated.**

Recommendations

2.1 The Legislative Auditor recommends that the Legislature consider amending W.Va. Code §12-4-14 to provide for greater oversight and accountability of state grant monies awarded to state and local government entities.

2.2 The Legislative Auditor recommends that the Legislature evaluate whether the Authority should continue to operate as an independent state agency, and if certain functions can be relocated within state government or eliminated.

Appendix A

WEST VIRGINIA LEGISLATURE
Legislative Post Audit Division

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Denny Rhodes
Director

January 30, 2017

Sonia D. Chambers, Director
Marilyn G. White, Director
West Virginia Health Care Authority
100 Dee Drive
Charleston, WV 25311

Dear Board of Directors:

This is to transmit a draft copy of the Special Report on the West Virginia Health Care Authority. This report is tentatively scheduled to be presented during the February meeting of the Joint Committee on Government and Finance. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from the Health Care Authority be present at the meeting to respond to the report and answer any questions committee members may have during or after the meeting.

We need to schedule an exit conference to discuss any concerns you may have with the report. Please notify us to schedule an exact time. In addition, we need your written response by noon on Monday, February 6, 2017 in order for it to be included in the final report.

We request that your personnel not disclose the report to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

Denny Rhodes

Enclosure

Appendix B

February 6, 2017

Mr. Denny Rhodes
West Virginia Legislature
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Charleston, WV 25305-0610

Re: Special Audit Report on the West Virginia Health Care Authority

Dear Mr. Rhodes:

Thank you for the opportunity to respond to the Special Report on the West Virginia Health Care Authority (HCA) compiled by the Legislative Post Audit Division. We appreciate the necessity of audits and special reports to monitor state agencies ensuring their missions are effective and efficient. We also appreciate the courteousness of your staff as this Special Report was being prepared.

We disagree with the assumptions and conclusions made within this report. There are several inaccuracies in the findings, numerous important pieces of information are omitted, and the conclusions presented reflect a fundamental lack of understanding of the health care system and activities of HCA.

We appreciate the need to streamline state government and are well aware of the budget shortfall. However, the elimination of Certificate of Need law and the dismantling of HCA will result in a significant negative economic impact to the State. No General Revenue dollars will be saved as HCA is entirely funded by Special Revenue.

Should you have any questions, feel free to contact us at 304-558-7000.

Very truly yours,

Sonia Chambers, HCA Board Member

Marilyn White, HCA Board Member

Enclosure: Agency Response to Special Audit Report

Executive Summary

The Health Care Authority's (HCA) role 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." W. Va. Code § 16-29B-1.

The Certificate of Need (CON) program is an effective and necessary regulatory function. The CON law should not be repealed and all HCA programs should remain intact. The HCA's structure should remain autonomous as the agency is far more effective in its independent role than as divisions across state government. The HCA's Special Revenue funding should be continued as it currently does not burden the State.

In response to the findings we maintain the following:

- CON works to assure that high cost services will not be overly duplicated and programs will have sufficient number to ensure quality.
- CON levels the playing field with out-of-state competition so that rural health safety-net providers continue to be able to serve local communities. This protects access to health care and jobs in those rural communities; hospitals are the largest private employer in 23 of West Virginia's counties.
- HCA only approves applications that meet CON's rigorous quality standards which mean fewer complications from surgeries and lower overall cost for health plans.
- The Legislative Audit Report failed to account for the modernization of CON law in the 2016 legislative session, when it compared West Virginia's CON law to other states' laws and found that West Virginia's is more restrictive.
- HCA issues decisions within reasonable time frames.
- The elimination of the continued oversight of the Cabell Huntington Agreement could result in the Federal Trade Commission expanding its sphere of influence over the West Virginia health system.
- The Clinical Analysis Division provides crucial data and analytic reports that inform crucial decisions and assist in addressing quality activities like reducing infections in hospitals.
- The Financial Analysis Division provides valuable independent information to providers, the public and policy makers about the financial well-being of the second largest employment sector in the state and the largest employer in many counties.
- Elimination of the agency will also eliminate the $1.6 million in grant funds available to small hospitals, rural clinics, county ambulance services, and dental clinics.
- The HCA is completely funded by Special Revenue dollars and these dollars will not travel with the programs. Without the HCA's revenue stream, these programs will cease to exist.

Issue 1: The West Virginia Health Care Authority's Certificate of Need Program is an ineffective and unnecessary regulatory function.

Agency Response:

The CON law should be continued for at least the following three reasons:

- CON protects rural health safety net hospitals;
- CON promotes quality care; and
- CON helps controls costs borne by the consumer

Protects Rural Health Safety Net

CON helps to preserve rural safety net services in West Virginia. Without CON, competition will enter the market and redirect patients out of state or allow outside entities to acquire local hospitals and then shut them down. This is much like a big box store chain coming into a community. This is not a trivial issue for West Virginia. West Virginia is surrounded by 60% of the nation's population with major health systems, which draw patients out of state.

Closure of rural hospitals would be devastating to local communities in terms of access to care and jobs. Absent rapid access to acute care, patients may choose to put off treatment and then end up getting much more expensive care in the Emergency Room or admitted to the hospital costing themselves, insurance companies, or state payers much, much more.

Hospital closure could cripple the local economy. The hospital is often the major employer in a rural community. It is the largest private employer in twenty three of West Virginia's counties.[1] One third of these rural hospitals are having significant financial difficulties. The loss of tax base from goods and services bought by the local hospitals also contributes to a negative spiral in the economy.

Safeguarding Quality

CON plays an important gatekeeping role in health policy by safeguarding quality. CON protects West Virginians who need high risk procedures, such as heart surgery. For hospitals to provide safe high risk surgeries or procedures, studies show that they must regularly perform them at high enough volumes to be proficient. Mortality rates for Medicare patients undergoing coronary artery bypass graft surgery were 22% higher for patients in states without CON laws than states with continuous CON law for the six-year period under review.[2] Quality health services are better for the patient with fewer complications and lower overall cost for health plans, such as Medicaid and PEIA.

Controlling Cost

The CON program helps control health care costs. For example, large companies such as the big three auto makers see CON as an asset. In 2002, DaimlerChrysler Corporation[3] (DCC) endorsed maintaining a CON program in Michigan. DCC noted that it may build new factories, expand or renovate, or close factories based in part on the cost and quality of health care in a geographic area. DCC noted that health care is its largest single component in producing a vehicle-larger than even the cost of steel. Accordingly, it tracked costs of health care in each of its major production areas. DCC found that the costs of health care per person are significantly less in states with CON programs than in states without CON. DCC notes that the design of the health benefit program does not vary by geographic region and that significant difference in relative costs occur between

[1] http://www.wvexecutive.com/west-virginias-largest-employers/

[2] http://health.hawaii.gov/shpda/files/2013/07/jama2002.pdf

[3] Certificate of Need endorsement by Daimler Chrysler Corporation February 2002.

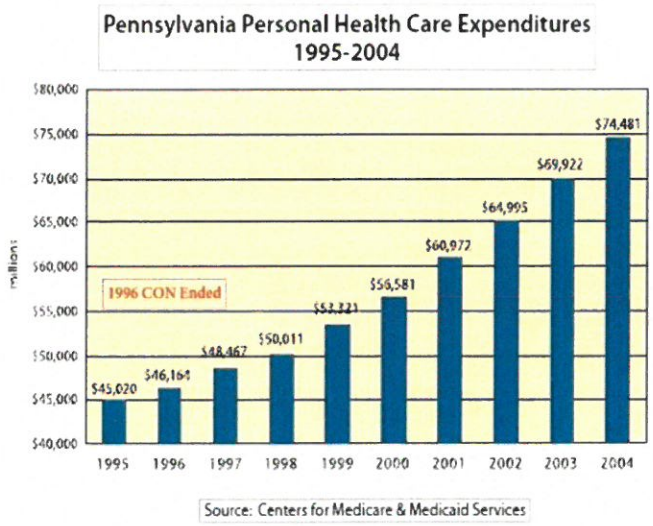
areas even after the data is standardized for gender and age. DCC noted that costs for health care are considerably higher in non-CON states, such as Wisconsin and Indiana, than in CON states such as Delaware, Michigan and New York.

Ford Motor Company (Ford) had similar findings. Ford noted that some legislators and health care providers have questioned the value of CON and whether it helps to contain health care costs. Ford noted that, as a multi-state company, with the same benefit plan it had the opportunity to examine comparable health care costs. Ford determined that states that eliminated CON for most services, such as Indiana and Ohio, consistently had the highest relative cost. Conversely, Michigan, with a CON program since 1972 covering a wide range of services, consistently had among the lowest relative costs. Kentucky and Missouri, which also have had CON programs covering a wide range of services, also had low relative costs. Ford noted that the consistent correlation between CON and lower costs "was quite notable because the pattern was the same across a range of different services."

General Motors Corporation (GM) supported the continuation of CON because it was an important tool to ensure cost-effective, high quality health care services. GM noted that some argue that deregulating health care facility expansion will trigger free-market forces of supply and demand and lead to lower costs. GM stated that it has not found that to be true based upon its vast experience operating in states that have varying degrees of CON regulation. GM stated that "traditional supply and demand theory doesn't work in the health care industry because often consumers only pay for a fraction of health care services or don't have enough information to make choices on quality. GM noted that its health care costs are highest in Indiana, a state with no CON regulation, and lowest in New York, a state with stringent CON regulation.

Another example of controlling costs is seen by an examination of states surrounding West Virginia. All states bordering West Virginia, except Pennsylvania, have a CON program. Pennsylvania ended its CON program in 1996. During the years that Pennsylvania had a CON program, the states' health care costs rose at $1.4 billion per year. Since Pennsylvania discontinued its CON program, health care costs have risen at $3.4 billion per year, or at almost 2.5 times the prior rate.[4]

[4] Pennsylvania Health Care Cost Containment Council October 2007



Personal health care spending in Pennsylvania rose 65.4% from 1995 to 2004 – from $45 billion to $74.5 billion.

The average rate of increase with CON $1.14 billion.
The average rate of increase without CON $3.14 billion.
This note added by WVHCA

Critical Condition: The State of Health Care in Pennsylvania • PHC4 •

The Auditor made a very simplistic comparison between healthcare costs and CON. The conclusion did not take into account the average age of West Virginians and the prevalence of chronic disease in calculating the cost. These are two large factors which are adjusted for in any credible health care cost or utilization report.

The report noted that West Virginia's per capita health care costs are $7,667 as of 2009. West Virginia ranks near the top in prevalence of cardiovascular deaths, obesity, smoking, cancer death, diabetes, and overall health outcomes.[5] These chronic health conditions significantly drive up the costs of per capita health care spending in the state. Given these statistics it is even more important to make sure rural areas have access to care and higher tech services, such as open heart surgery and radiation therapy services, and have the volume clearly associated with quality.

CON Decisions Are Rendered Timely

The auditors argue that the CON process takes too long. CON decisions which can have such a significant impact on the quality of care, access to care and the financial viability of one of the community's greatest financial drivers should not be considered hastily. The CON program does not cause inappropriate delays.

In an uncontested CON matter a decision is due within 60 days from the date the application is placed in a batch cycle. W.Va. Code § 16-2D-14. An application is placed in a batch cycle once it has been deemed complete and batch cycles occur the fifteenth day of the month and the last day of the month. This timeframe is not calculated from the date that the application is filed.

- **The entire review process from the filing of the letter of intent to the issuance of the decision could take a maximum of 95 days.**

[5] http://www.americashealthrankings.org/explore/2016-annual-report/state/WV

- **The Authority is rendering its decisions on uncontested applications, on average, within 46.5 days.**
- **With respect to the exemption process, which was not discussed, an exemption decision is due within 45 days of filing of the application. W.Va. Code § 16-2D-11. The Authority is rendering the decision, on average, in 18.5 days.**
- **Finally, the Authority is rendering its decisions on determination of reviewability, on average, in 15.95 days.** A determination of reviewability decision is due within 45 days of receipt of a request.

CON Process Modernized

The auditors argue that the CON process is expansive. Last year, the HCA partnered with the Legislature in modernizing the CON law to allow for more flexibility and exemptions. When the Legislative Auditor determined that West Virginia had one of the most extensive CON programs in the United States, the Legislative Auditor failed to take into account the substantive impact that HB 4365, effective June 10, 2016, has upon the CON program. These changes will result in a more flexible program that can quickly address such public health issues as substance abuse.

High Approval Rate of CON

The report noted that the HCA is ineffective because it approves a large percentage of applications. In the remaining areas CON standards are set high on purpose to deter entry just like with banks or public utilities. HCA works to fully educate and inform potential applicants regarding CON laws to prevent the filing of applications that will be denied resulting in undue costs to an applicant. HCA also utilizes the Determination of Reviewability (DOR) process which allows applicants to ask the HCA whether their project is subject to review prior to filing an application.

CON is a Failure Because of the Many MUA or HPSA Designations

The auditors' conclusion that the CON program has failed because many counties in West Virginia are designated as MUAs or HPSAs again indicates that the auditors don't understand health care. The designation of Medically Underserved Areas (MUA) DOES NOT relate in any way to CON.

MUA designations are made based on shortages of primary medical care, dental, or mental health providers, as well as a high infant mortality rate, a high poverty rate or a high percentage of elderly population. CON does not review the majority of these services so the argument is invalid.

Additional Consequences

The report also fails to recognize one major consequence of eliminating CON. By West Virginia law, the HCA is required to monitor and supervise the merger of Cabell-Huntington Hospital and St. Mary's Hospital. Because of this state mandated oversight, the Federal Trade Commission dismissed its complaint, allowing the merger to proceed. Without the HCA in place, the Federal Trade Commission may re-institute its action to block the merger. This is bad for West Virginia because the merger enhances recruitment of specialty providers, mental health services and

treatment of substance abuse, enhancement of population health status consistent with health goals of the HCA and preservation of existing academic and clinical educational programs.

Issue 2: If the Legislature Repeals the Certificate of Need process, the Legislative Auditor suggests a restructuring of the Health Care Authority and its remaining functions.

Legislative Audit Recommendation 2.1: The Legislative Auditor recommends that the legislature consider amending W. Va. Code 12-4-14 to provide greater oversight and accountability of state grant monies awarded to state and local government entities.

Agency Response:

The HCA defers to the Legislature with regard to the amendment of its rule.

Legislative Audit Recommendation 2.2: The Legislative Auditor recommends that the Legislature evaluate whether the Authority should continue to operate as an independent state agency, and if certain functions can be relocated within state government or eliminated.

Funding will not travel with relocated HCA divisions and these valuable functions will perish. The HCA is primarily funded by several Special Revenue funding sources including:

- CON application fees that support CON staff;
- Hospital assessments fees; and,
- Data request fees.

The report assumes that if the HCA is dissolved, programs can be relocated to other agencies. Without HCA's revenue stream, these programs will cease to exist. Due to the budget shortfall, other agencies will not have the funding to assume the HCA's mission. These include:

- Funding for three positions and administrative support for the State Privacy Office.
- Funding for ten positions for Financial Analysis and Clinical Analysis.
- Administrative support and budget of $1.6M annually for the Rural Health Systems Program Grants and Hospital Assistance Grants.

The HCA has a budget of $1.6M annually for the Rural Health Systems Program Grants and Hospital Assistance Grants. These grants include crisis funds that are available to rural hospitals and health care providers to fund emergency projects or essential items needed when health services or patient care is at risk. These grants are a safety net to rural communities when facing potential foreclosure and no other grants of this type are available within West Virginia. The loss of these grants will harm communities and jeopardize continuity of health care. Recent grant recipients include:

- Critical Access Hospitals
- Free Clinics
- Primary Care Centers
- Small Rural Hospitals
- County Commissions and Ambulance Authorities
- Nonprofit Healthcare Providers

The following counties benefited from the grant program from FY 2011 through FY 2015:

Brooke	Grant	Kanawha
Cabell	Hardy	Lincoln
Calhoun	Harrison	Nicholas
Fayette	Jackson	Pocahontas
Ritchie	Summers	Taylor
Tucker	Tyler	Webster

The Legislative Audit found: ***The Financial and Clinical Analysis Divisions collect and publish data, but the Legislative Auditor is unable to determine its value and use.***

Agency Response:

The HCA is charged to serve as an independent resource to collect data on health care services and the financial viability of health care facilities. This data is used extensively by policy makers, consumers, providers, health plans and others.

The HCA is the sole source of this data in many instances. There has to be an independent source for information on this imperative sector of West Virginia's economy.

HCA makes a tremendous amount of useful data publicly available on its website. Several automated tools are provided:

CompareCareWV was created to inform consumers about the cost and quality of medical procedures they might need. The site shows the actual overall charges for all typical procedures, including all peripheral costs for each hospital. It also provides a quality report for each hospital on all major procedures. This allows consumers to make informed decisions about cost and quality and cause providers to adjust charges to be competitive.

YODA (Your Online Document Archive) provides online access for all citizens to all documents available at HCA. The documents on the site are text searchable, so that any document related to a topic can be found and acquired. Most documents are available in a PDF format but files that contain numeric information are available as Excel files. We have permission from George Lucas to use the YODA name and image.

HealthIQ provides a graphical user interface to query our Inpatient Hospital data. It currently contains fifteen years of data. It creates custom reports on the fly that filter data by Facility, County, Age Group, Sex, Payor Group, DRG, MDC, Discharge Status, Type of Admission, Source of Admission, Diagnosis and/or Procedure. We have an updated site ready for publication that provides trend graphs and the ability to get reports in either PDF or Excel format. We will be adding data maps later this year.

The number of data requests in the last year by site is as follows:

HCA Website Query Tools	Number of Data Requests
CompareCare WV	65,798
Health IQ	137,257
Distinct Users	23,698
YODA	86,749
Distinct Users	7,519

These data assists stakeholders – Legislature, state agencies, consulting agencies and the public – in understanding the cost, quality and utilization of health care in WV. CompareCareWV, HealthIQ and YODA are direct sources for everyone to identify the diagnoses driving health care utilization and to prepare for present and future health care resources. These factors are very important for developing the State Health Plan, utilization and the many quality improvement projects in the state.

Clinical Analysis Division

The Clinical Analysis Division maintains the West Virginia Hospital Inpatient Data System (WVHIDS), which collects and analyzes uniform billing (UB) data required to be submitted to the HCA by all non-federal hospitals. These data show hospital cost, health care access, quality and costs in order to inform regulatory, policy, and planning efforts.

The HCA has provided the core function of gathering the hospital inpatient data for many years. Expanding capabilities by also collecting outpatient data allows far greater analysis of disease and healthcare utilization, need for service expansion, and trending of healthcare issues across the state.

State Health Plan

The State Health Plan is the major roadmap for state agencies, providers, community leaders, the Legislature and stakeholders alike to use for improving health and wellness across the state. By using available data, stakeholder and community input and provider input, the State Health Plan is currently being developed with publication expected in early 2017. Given that West Virginia is currently one of the unhealthiest states in the nation and has the highest rates of smoking, obesity, diabetes, cardiovascular diagnoses, substance abuse/opioid addiction and senior population, the State Health Plan is the independent source for organizing state agencies, health insurers, providers and stakeholders to address population health, wellness and improvements across the state. HCA operates independently and without bias, which is important to external stakeholders with respect to health planning and trust to transparent sharing of data.

The State Health Plan is focused to drive improvement on the opioid epidemic and behavioral health services, access to care, obesity, smoking and long-term care.

Healthcare Associated Infection program

The Healthcare Associated Infection Program, which includes a board comprised of public and private providers and stakeholders, monitors data submission of each West Virginia hospital's infection rate and aggregates the data to show worsening rates of infections, improvements, and trends. The HCA works collaboratively with Department of Health and Human Resources' Bureau for Public Health to determine from the data where there may be a public health hazard that needs remediated. The program identifies areas of quality concern and develops quality

improvement projects to address issues. As an autonomous entity, the HCA is positioned to determine strategies based on the data and the needs of the community and the WV population rather than on the fiscal pressures of the state.

Some areas have seen great improvement as noted below. Other areas need focus and improvement. Last year, a quality improvement project focused on improving the rate of a deadly infection, Clostridium *difficile*. Status is measured by whether the rate is above or below the expected rate based on targets and national averages.

For the most recent reporting year, the inpatient hospital infections show the following improvements:

Type of Infection	Type of Facility	Outcome
Central Line-Associated Blood Stream Infections	General Acute Care	54% fewer than expected
	Long-Term Acute Care Hospital	30% fewer than expected
Catheter –Associated Urinary Tract Infection	General Acute Care	57% fewer than expected
	Long-Term Acute Care Hospital	16% fewer than expected
	Critical Access Hospital	86% fewer than expected
	Rehabilitation Hospital	81% fewer than expected
Surgical Site Infections -- Colon	General Acute Care	40% more than expected
Surgical Site Infections – Abdominal Hysterectomy	General Acute Care	15% more than expected
Methicillen –Resistant Staphylococcus aureus (MRSA)	General Acute Care	6% more than expected, up from 16% fewer the previous year
Clostridium *difficile* (CDI)	General Acute Care	2% fewer than expected
Healthcare Personnel Influenza Vaccinations	All Inpatient Facilities	82.06% of hospital employees vaccinated, which is increasing yearly.

Other Quality Improvement Activities

HCA data are also used to develop and participate in quality improvement projects. Recently, the HCA contributed the data for and participated in a project to reduce non-medically necessary C-Sections prior to 39 weeks. Babies who are born before 39 weeks have a much greater chance of being in distress and ending up in the NICU costing everyone significantly more money. The result was a reduction in the non-medically necessary C-Sections prior to 39 weeks by over 50%. Currently, the HCA is participating in and utilizing the data to determine the best approach for reducing neonatal abstinence syndrome (opioid withdrawal) that will also be used in the State Health Plan for statewide implementation.

Financial Disclosure and Analysis

The health care sector is one of the largest economic drivers in West Virginia. Hospitals and other health care providers make up both a large employment sector and a large revenue generator in the state. In many counties it is the largest. Having complete, independent and objective

information about this sector is essential to policy makers as they make decisions about reimbursement levels and fund programs.

The value and use of the data collected by the Financial Analysis Division is evidenced by the following four facts:

1. The Financial Analysis Division received and filled 61 FOIA requests in 2016. These requests resulted in the transfer of 2,333 electronic files.
2. The data collected is requested and utilized by numerous organizations and individuals at the national, state and local level. The following is just a sample of such organizations and individuals:
   - National Hospice and Palliative Care Organization (NHPCO)
   - Hospice Council of WV
   - WV Center for End of Life Care
   - WV Office of Accountability and Management Reporting
   - WV Bureau for Public Health
   - WV Bureau for Medical Services
   - WV DHHR Finance Department
   - WV Behavioral Health Providers Association
   - WV Office of Epidemiology
   - WV Hospital Association
   - Agency for Healthcare Research and Quality (AHRQ)
   - Optum Insight – a national organization that produces a premier financial hospital benchmarking publication, *Almanac of Hospital Financial & Operating Indicators*.
   - Numerous healthcare consultants, researchers, graduate students, attorneys, hospital personnel, bankers, legislators, etc.
3. The Uniform Financial Report, submitted by all WV hospitals, provides a wealth of information, much of which is not available through any other source. Some of the information available through the Uniform Financial Report include:
   - Data broken out by payor category - Medicare, Medicaid, PEIA, Other Governmental and Nongovernmental.
   - Utilization – inpatient and outpatient
   - Revenues billed and collected
   - Contractual Allowances
   - Uncompensated care
   - Expenses
   - Service units provided
   - Other and non-operating revenues received through investments
   - Staffing levels and costs
   - Financial health of the hospital
4. The data collected by the Financial Analysis Division is compiled and published in the HCA Annual Report. This report includes written analyses, historical trends, financial ratios, graphs and data tables providing a comprehensive and robust overview of the financial status and utilization of the state's health care providers. It is believed to be the only single-source document available containing this information.

The Annual Report provides data on hospitals, home health agencies, hospice agencies, nursing homes, behavioral health centers, ambulatory surgery centers, kidney dialysis centers and primary care centers. Data for each individual provider is included. This allows for monitoring the financial health of individual facilities. As the state focuses on battling the opioid epidemic, it will be essential to monitor the treatment centers in the state. In 2015, the nine methadone treatment centers together realized a profit of $11.9 million with a total margin of 49%. Without the data collected by the Financial Analysis Division, the state will no longer be able to monitor the growing profits of these treatment centers.

The Legislative Audit also found that: ***The State Privacy Office and West Virginia Health Information Network operate with minimal administrative support from the Health Care Authority.***

Agency Response – General

As an independent entity included under the broad Department of Health and Human Services umbrella, HCA is able to serve as a catalyst for important functions that neither other state agencies nor the private sector would do. Two examples of this are the State Privacy Office and the West Virginia Health Information Network. HCA is not consumed with the day to day program tasks of other divisions and is able to apply for federal grants to develop important programs that may not have produced short term gain but are now definitely poised to produce real value.

The HCA provides significant (not minimal) administrative support. Economies of scale are realized in

- Fiscal and Human resources;
- Office space; and,
- Use of supplies and equipment

State Privacy Office

Because the State Privacy Office is positioned within an independent and autonomous agency – the HCA - it garners the requisite trust required to effectively collaborate across state government and beyond.

In partnership with the Board of Risk and Insurance Management and the Cyber Security Office, WVOT, the State Privacy Office provides support and technical assistance to a variety of organizations around urgent and sensitive matters, including privacy breaches. It is imperative to the people and organizations served by the State Privacy Office that it remain impartial and available to assist others in crisis. According to a 2016 Ponemon Institute Report, the average privacy breach costs an organization $221 per lost record and an average of $7.01 million per event. The State Privacy Office, sponsored by the HCA, is well positioned to continue to lead efforts to protect citizens' and employees' privacy and to continue to reduce privacy related risks.

West Virginia Health Information Network (WVHIN):

HCA served as the catalyst for the WVHIN bringing together the broad spectrum of health care providers and payers in West Virginia. HCA received federal grant funds, state funds, private donations and special revenue funds to develop the infrastructure. It is quite unlikely that private providers in a small state like West Virginia would have been able to garner the resources necessary to build the infrastructure. Although the WVHIN has experienced some difficulties, it

did not fold. The new partnership with the HIE serving Maryland and DC has allowed it to rapidly accelerate connectivity, participation and functionality.

Conclusion

It is more important, now than ever, to unite government and private industry to jointly tackle West Virginia's health access, quality and cost issues, such as the opioid epidemic, to improve the health and health care of all West Virginians. The HCA is charged by law to be autonomous, unbiased and independent to convene these disparate interests, obtain consensus and chart the course for West Virginia's health care regulatory system. Further, HCA is the central repository for data for the purposes of policy, planning, and research into opportunities for cost reduction and control. Maintenance of an independent status contributes to stakeholder confidence that health planning and policy formulation in West Virginia is based on needs of the population and not driven solely by the fiscal pressures of the State.

Appendix C
Objective, Scope, and Methodology

The Post Audit Division within the Office of the Legislative Auditor conducted this review as authorized by Chapter 4, Article 2, Section 5 of the *West Virginia Code,* as amended.

Objectives

The objective of this review is to analyze the necessity and efficiency of the operations of the West Virginia Health Care Authority and its primary sections: Certificate of Need; Rural Health Systems Program; Financial Analysis Division; and Clinical Analysis Division.

Scope

The scope of this review consists of all operations of the Health Care Authority between 2011 and 2015. This information includes all applications, decisions, and orders issued by the Certificate of Need program, all grants awarded, and the data collected by the two analysis divisions. This audit did not evaluate whether Certificates of Need were appropriately granted or denied, nor did it evaluate the appropriateness of any grant award or denial.

Methodology

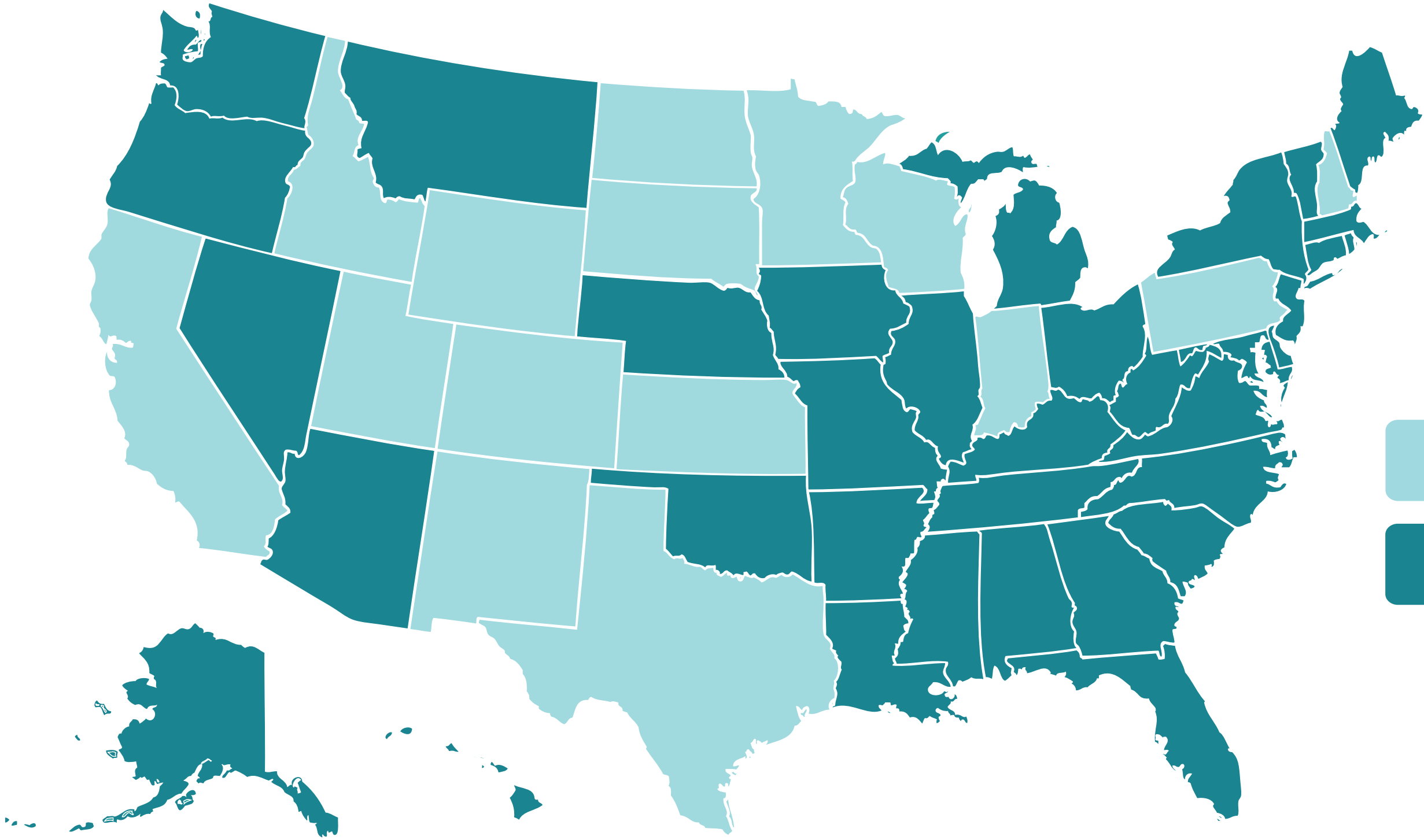
Post Audit staff gathered and analyzed several sources of information and assessed the sufficiency and appropriateness of the information used as evidence. Testimonial evidence was gathered through interviews with various agencies that oversee, collect, or maintain information. The purpose for testimonial evidence was to gain a better understanding or clarification of certain issues, to confirm the existence or non-existence of a condition, or to understand the respective agency's position on an issue. Such testimonial evidence was confirmed by either written statements or the receipt of corroborating or physical evidence.

Auditors confirmed with the Health Care Authority that all relevant Certificate of Need documents over the scope of this audit were contained in the Authority's Online Document Archive. All applications, decisions, and reviewability decisions were accessed and analyzed by Post Audit staff. Academic and empirical literature from various research institutions, colleges, and federal agencies were analyzed.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Note: On Monday, February 6, 2017, the Legislative Auditor's wife began employment as the Governor's Deputy Chief Counsel. This audit report was completed prior to this date. Therefore, the Legislative Auditor's Office does not believe there are any conflicts of interest needed to be reported.

CERTIFICATE-OF-NEED (CON) REGULATION IN THE UNITED STATES (Present)



No CON regulation

CON regulation

MERCATUS CENTER
George Mason University

Source: American Health Planning Association, *National Directory: State Certificate of Need Programs, Health Planning Agencies, Annual Volumes, 1994–2012*, 2012.

Produced by Matthew Mitchell and Christopher Koopman, September 2016.

Regulated Services by State, 2016

Regulated Services	AL	AK	AR	AZ	CT	DE	FL	GA	HI	IL	IA	KY	LA	ME	MD	MA	MI	MS	MO	MT	NE	NV	NJ	NY	NC	OH	OK	OR	RI	SC	TN	VT	VA	WA	WV	DC	Counts by Service
Acute Hospital Beds	x	x			x	x	x	x	x	x	x	x			x	x	x	x	x			x	x	x	x			x	x	x	x	x	x	x	x	x	28
Air Ambulance									x							x	x					x										x						5
Ambulance Services, Ground (generally not counted as a CON state)				x					x			x												x													4
Ambulatory Surgical Centers (ASC)	x	x			x	x		x	x	x	x	x		x	x	x	x	x		x		x	x	x	x			x	x	x	x	x	x	x	x	x	28
Burn Care	x	x					x		x						x								x	x	x			x			x	x		x	x	x	14
Cardiac Catheterization	x	x			x	x	x	x	x	x	x	x		x	x	x	x	x	x				x	x	x				x	x	x	x	x	x	x	x	27
Computed Tomography (CT) Scanners		x			x			x	x		x						x		x				x	x			x	x	x	x	x	x		x	x	17
Gamma Knives	x	x						x	x		x			x		x	x	x	x				x		x				x	x		x	x			x	17
Home Health	x		x				x	x	x			x			x			x		x			x	x	x				x	x	x	x		x	x	x	19
Hospice	x		x				x		x		x	x			x								x	x	x			x	x	x	x	x		x	x	x	18
Hypodermic Syringes and Needles																								x													1
Intermediate Care Facilities/Mental Retardation (ICF/MR)	x		x				x	x	x	x	x	x	x		x	x		x	x	x	x	x	x	x	x		x	x	x	x	x	x	x		x	x	28
Linear Accelerator Radiology					x														x				x		x				x		x						6
Lithotripsy		x				x		x	x							x	x		x				x	x	x			x		x	x	x	x			x	16
Long-Term Acute Care (LTAC)	x	x			x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x		x	x	x			x	x	x	x	x	x	x	x	x	30
Nursing Home Beds/Long-Term Care Beds	x	x	x			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	34
Medical Office Buildings								x																								x				x	3
Mobile Hi Technology (CT, MRI, PET, etc.)		x			x				x		x	x					x	x	x				x	x	x				x	x		x	x		x	x	17
Magnetic Resonance Imaging (MRI) Scanners		x			x			x	x		x	x				x	x	x	x				x	x	x			x	x	x	x	x	x	x		x	x	21
Magnetic Source Imaging (MSI) Scanners																																	x					1
Neo-Natal Intensive Care	x	x					x	x	x	x		x			x	x	x						x	x	x			x	x	x	x	x	x	x	x	x	22
Obstetrics Services	x	x						x	x	x		x			x				x				x	x					x	x	x	x	x	x	x	x	18
Open-Heart Surgery	x	x					x	x	x	x	x	x			x	x	x	x					x	x	x				x	x	x	x	x	x	x	x	23
Organ Transplants	x	x					x		x	x	x	x			x	x	x						x	x	x				x			x	x	x	x	x	19
Positron Emission Tomography (PET) Scanners		x			x	x		x	x		x	x				x	x	x	x				x		x			x	x	x	x	x	x		x	x	21
Psychiatric Services	x	x	x		x		x	x	x		x	x		x	x	x	x	x	x			x	x		x		x	x	x	x	x	x	x	x	x	x	28
Radiation Therapy	x	x			x	x		x	x		x	x		x		x	x	x	x					x	x			x	x	x	x	x	x		x	x	23
Rehabilitation	x						x	x	x	x	x	x		x	x	x		x	x	x	x	x	x	x	x			x	x	x	x	x	x	x	x	x	27
Renal Failure/Dialysis	x	x							x	x				x				x					x	x	x							x		x	x	x	13
Assisted Living/Residential Care Facilities			x				x					x	x		x	x			x				x		x							x					10
Subacute Services		x					x		x	x													x		x		x		x	x	x	x		x		x	13
Substance/Drug Abuse	x				x		x	x	x			x		x	x	x		x	x	x		x	x	x	x		x	x	x	x	x	x			x	x	24
Swing Beds	x						x		x					x			x	x		x								x			x	x		x		x	12
Ultra-Sound									x					x																			x			x	x	5
Counts by State	20	20	6	1	12	8	17	20	29	13	17	21	3	12	17	19	18	18	18	8	4	8	26	23	25	1	5	17	23	22	23	30	20	17	23	28	

Source: Compiled from state laws, current regulatory documents, agency forms, and direct communication with regulators in each state

Produced by Christopher Koopman, Anne Philpot, and Gregory Burns, September 27, 2016

YEAR	First Name	Last Name	Organization	Data Request Type	Data Year(s)	Description
2014	Stephanie	Reynolds	US Federal Trade Commission	Custom	2011, 2012, 2013	Civil Investigation Demand
2014	Katie	Oscanyan	BPH, MCH - Injury	Record - Level	2011-2012	ECODES for injury MVA
2014	Cindy	Woodyard	Hospice Care Corporation	Health IQ	2012	HealthIQ Mimic for 2012
2014	Shaylee	Mehta	OMC/Family HealthDivision of Research, Evaluation and Planning	Principal diag code/ICD9	2008-2012	ICD9 Codes 520-529 By AG and Year
2014	Katie	Oscanyan	BPH, MCH - Injury	Ecodes injury	2011-2012	ECODES for injury All Ages
2014	Melissa	Baker	BPH/OMCH	Custom Analysis	2012	ECODES for injury
2014	Marilyn	Smith	Community Health Systems	Record - Level	2010, 2011, 2012	Health Care operations
2014	Chris	Clark	WV DHHR - Secretary's office - Planning/Res. GoHelp		2012	Prevention Quality Indicators
2014	Brenda	Grant	CAMC	PTDRG	2013	All data fields
2014	Jim	Berton	King's Daughters	Record - Level	2012	Market share analysis/CON - custom
2014	Whitney	Hess	BJC Inc.	Record - Level	2012	Standard acute files
2014	Meagan	Stabler	WVU School of Public Health, Dept. of Epidemiology	Custom - PTDX	2007-2013	Drug w/d syndrome in newborns
2014	Feifei	Sun	Highmark Health	Custom	2012	Market analysis
2014	Whitney	Hess	BJC Inc.	Custom	2012	Cardiac Cath + age group
2014	Michael	Cartwright	Cabell Huntington	Record - Level	2012	Health care data analysis
2014	Allison	Young	USA Today	Record - Level	2010-2013	Research re: rising maternal mortality and morbidity
2014	Gregory	Hudson	Valley Health Link	Record - Level	2012-2013	Health care data analysis
2014	Jim	Berton	King's Daughters	Custom	2013	Market share analysis/CON - custom
2014	Lisa	Chamberlin	Cabell Huntington	Custom	2013	Planning analysis/utilization
2014	Melissa	Baker	BPH/OMCH	Custom/Analysis	2011-2013	MVA
2014	Robin	Eckhart	Arnett & Foster	PTDRG/PTZIP	2013	Health care data analysis
2014	Michael	Cartwright	Cabell Huntington	Custom	2013	Health care data analysis
2014	Amanda	Lyda	Dixon Hughes Goodman LLP/Ohio Valley	PT FILE	2012-2013	PTZIP
2014	Jason	Moore	Stratasan, LLC	Custom/Analysis	2013	Market share analysis/CON - custom
2014	Courtney	McAneny	Dixon Hughes Goodman LLP/Ohio Valley	Record - Level	2013	Research and market share
2014	Brenda	Grant	CAMC	Custom/Statewide	2013	Stategic planning
2014	Brenda	Grant	CAMC	Custom	2013	Strategic planning
2014	Daniel	DePonte	Western Maryland Health System Corp./Oncology Solutions LLC	Custom	2011-2013	Healthcare data analysis/reporting/planning
2014	Mabel	Owusu-Ankomah	DHHR BPH Div. Health Promotion & Chronic Disease	Custom	2012-2013	Asthma
2014	Brenda	Grant	CAMC	Custom	2011-2013	All services - rate review
2014	Den	Sek	HCA - Lewis Gale Regional Health System	Custom	2009-2013	Statewide all services reporting/analysis
2014	Marcy	Kelley	Memorial Health Systems	Standard reports	2013	County/hospital
2014	Nancy	Vest	WVU Healthcare	Custom	2013	CON/Rate Setting
2015	Whitney	Hess	BJC Inc.	PTZIP & PTDRG	2013	CON rate setting
2015	Dave	Werkin	Trinity Health System	Custom	2011-2013	Health care data analysis
2015	Katie	Oscanyan	OMC/Family HealthDivision of Research, Evaluation and Planning	Custom analysis	2013	Ecode frequencies by age group
2015	Paul	Reuscher	IMS Health	Custom analysis	2012-2013	Statewide acute
2015	Salyem	DePasquale	Epi, CSHCN, CED, WVU	Custom analysis	2010-2013	Data used for MCH Title V needs assessment
2015	Katie	Oscanyan	OMC/Family HealthDivision of Research, Evaluation and Planning	Custom analysis	2013	Ecodes acute poisoning
2015	Dan	Christy	Director/HSC/WV DHHR BPH	Custom analysis	2009-2013	COPD data

YEAR	First Name	Last Name	Organization	Data Request Type	Data Year(s)	Description
2015	Steve	Parker Marsh	Novant Health Shared Services	Custom	2010-2013	Healthcare analysis, planning and CON
2015	Whitney	Hess	BJC inc.	Custom	2013	Payor variable instead of group
2015	Dan	Christy	Director/HSC/WV DHHR BPH	Custom analysis	2013	Uncompensated Care births
2015	Katie	Oscanyan	BPH, MCH - Injury	Record - Level	2013	ECODES accidents/poisonings
2015	Michael	Cartwright	Cabell Huntington	Custom	2010-2012	Health care data analysis
2015	Erica	Thomasson	WV BPH Office of Environmental Health Services	Custom	2007-2013	CDC environments PH tracking
2015	Richard	Puckett	Princeton Community Hospital	PTZIP	2010- 2013	Analysis
2015	Tara	Gallagher	Hammes Company/Ohio Valley Medical	Custom	2011- 2013	HC data analysis re: ambulatory network plan
2015	Marcy	Kelley	Memorial Health System	Custom	2014, 2012, 2013	Research
2015	Dr. James	Kaplan	DHHR BPH Office of the Medical Examiner	Custom	2007-2013	IV drug overdose Public Health Conf.
2015	Daniel	DePonte	Oncology Solutions/Ohio Valley Medical	Custom	2014, 2012, 2013	Healthcare data analysis/reptg./planning
2015	Brian	Kelbaugh	Bluefield Regional Medical Center	Custom	2007-2010	dishcarge data for hospital auditors
2015	Kimberly	Repac	Western Maryland Health System Corp. / Truven	Standard & Custom	2012, 2013, 2014	Market share analysis
2015	Brenda	Grant	CAMC	Custom	2014	Stategic planning
2015	Patrick	Saale	LifePoint Health	Custom	2014	Strategic plan/data analy. Logan/Raleigh
2015	Whitney	Hess	BJC Inc.	PTZIP PTDRG	2014	Analysis for CON applications
2015	Jason	Moore	Stratasan, LLC	Custom	2014	Market share analysis/CON - custom
2015	Nancy	Vest	WVU Healthcare	Custom	2014	CON/Rate Setting
2015	Robin	Eckhart	Arnett Carbis Toothman LLP	PT file	2014	CON
2015	Lisa	Chamberlin Stump	Cabell Huntington	Custom	2014	Planning analysis/utilization
2015	Steve	Levy	Valley Health Systems	Custom	2014	Healthcare data analysis
2015	Richard	Puckett	Princeton Community Hospital	PTZIP	2014	Analysis
2015	Salma	Bibi	UC Berkeley, Center for Organizational Innovation Research	Custom	2011, 2012, 2013, 2014	Analysis re: SIM initiative
2015	Stephanie	Reynolds	US Federal Trade Commission	Custom	2014	Civil Investigation Demand

Appendix G

WEST VIRGINIA LEGISLATURE
Legislative Post Audit Division

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Denny Rhodes
Director

November 10, 2016

James L. Pitrolo, Chairman
Sonia D. Chambers, Director
Marilyn G. White, Director
West Virginia Health Care Authority
100 Dee Drive
Charleston, WV 25311

Dear Board of Directors:

As part of the audit process, the audit team has reviewed operations at the Health Care Authority to determine what areas will be chosen for audit. This process is ongoing throughout the audit and may prompt multiple reports. We have identified the following objective for our review. The scope of the audit has been determined as Fiscal Year 2011 to present; however, the scope can be expanded due to the need for further review and/or additional information such as historical data. Our objective for the audit is as follows:

1. *Analyze the necessity and efficiency of the operations of the West Virginia Health Care Authority and four of its primary sections:*
    a. *Certificate of Need*
    b. *Grant Programs*
    c. *Financial Analysis Division*
    d. *Clinical Analysis Division*

    Analysis will include an assessment of the agency's operations, outputs, beneficiaries of its services, and whether efficiency can be improved.

This objective is subject to changes. Additional objectives and/or changes deemed significant will be communicated to you as our audit progresses. If you have questions regarding the objective, please contact Melissa Bishop, CPA, Audit Manager at (304) 347-4880. Thank you for your time and assistance with the audit.

Respectfully submitted,

Denny Rhodes

Denny Rhodes, Director
Legislative Post Audit Division

c. Aaron Allred, Legislative Auditor