WEST VIRGINIA SECRETARY OF STATE

MAC WARNER

ADMINISTRATIVE LAW DIVISION

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Office of West Virginia
Secretary Of State

NOTICE OF FINAL FILING AND ADOPTION OF A LEGISLATIVE RULE AUTHORIZED BY THE WEST VIRGINIA LEGISLATURE

AGENCY: Health

TITLE-SERIES: 64-70

RULE TYPE: Legislative Amendment to Existing Rule: Yes Repeal of existing rule: No

RULE NAME: Primary Care Support Program

CITE STATUTORY AUTHORITY: 16-2H-2(d)

The above rule has been authorized by the West Virginia Legislature.

Authorization is cited in (house or senate bill number) SB 339

Section 64-5-1(e) Passed On 3/5/2020 12:00:00 AM

This rule is filed with the Secretary of State. This rule becomes effective on the following date:

April 15, 2020

This rule shall terminate and have no further force or effect from the following date:

April 15, 2025

BY CHOOSING 'YES', I ATTEST THAT THE PREVIOUS STATEMENT IS TRUE AND CORRECT.

Yes
April L Robertson -- By my signature, I certify that I am the person authorized to file legislative rules, in accordance with West Virginia Code §29A-3-11 and §39A-3-2.

TITLE 64
LEGISLATIVE RULE
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH

SERIES 70
PRIMARY CARE SUPPORT PROGRAM

§64-70-1. General.

1.1. Scope. This rule establishes processes for the administration of the primary care support program created within the Bureau for Public Health.

1.2. Authority. -- W. Va. Code §16-2H-2(d).

1.3. Filing Date. -- April 15, 2020.

1.4. Effective Date. -- April 15, 2020.

1.5. Sunset Provision. -- This rule shall terminate and have no further force and effect on April 15, 2025.

§64-70-2. Definitions.

2.1. "Bureau for Medical Services" or "BMS" means the division within the West Virginia Department of Health and Human Resources (DHHR) that is responsible for administration of the Medicaid program in West Virginia.

2.2. "Bureau for Public Health" or "BPH" means the division within DHHR that carries out the public health functions of DHHR.

2.3. "Director" means the commissioner of BPH or his or her lawful designee.

2.4. "Community-Based Board of Directors" means a board of directors composed of members who reside within the service area of the primary care center under consideration.

2.5. "Federally Qualified Health Center (FQHC)" means an entity that meets the United States Health Care Financing Administration definition of a federally qualified health center promulgated at 42 CFR § 405.2401.

2.6. "Federally Qualified Health Center Look-alike" or "Look-alike" means a public or not-for-profit health center that meets the eligibility requirements to receive a federal public health services grant under the "Public Health Services Act," 42 U.S.C. 254b, but does not receive grant funding.

2.7. "Nonprofit" means an entity registered with the secretary of state as a nonprofit organization and is recognized as such for tax purposes or having filed an application for such designation.

2.8. "Primary Care Center" means an organization which has as its purpose the delivery of primary care

services.

2.9. "Primary Care Service" means a health care service, including medical care, that emphasizes first-contact patient care and assumes overall and ongoing responsibility for the patient in both health maintenance and treatment of illness. Primary care involves a unique interaction between the patient and primary care physician or a multi-disciplinary team under the supervision of a physician or both. The appropriate use of referrals and community resources is an important part of effective primary care. The care is generally provided by a physician but may be provided by other members of a multi-disciplinary team such as registered nurses, nurse practitioners, physician assistants, and nurse-midwives. The purpose of this interaction is to achieve comprehensive coordination of health care including educational, behavioral, biological, and social aspects of care. It is a patient care-oriented approach which emphasizes the continuity of care over the full spectrum of health services. It begins with patient assessment, wellness, and prevention through medical management, lifestyle modification, and health education. The primary care provider is the patient's advocate through the complex system of health care delivery.

2.10. "Program" means the Primary Care Support Program within BPH.

2.11. "Related Organization" means any organization, whether publicly owned, nonprofit tax-exempt, or for profit, related to a primary care center through common membership, governing bodies, trustees, officers, stock ownership, family members, partners, or limited partners, or a subsidiary, foundation, related corporation, joint venture, or other similar organization, if such similar organization controls or is controlled by the primary care center through contracts, or other legal documents that allow the organization the authority to direct any of the primary care center's activities, management, or policies. A subsidiary, foundation, related corporation, joint venture, or other similar organization shall also be considered a "related organization" in the following situations:

2.11.1. The subsidiary, foundation, related corporation, joint venture or other similar organization has solicited funds in the name of the primary care center with the express or implied approval of the primary care center, and any portion of the funds were intended by the contributor, or otherwise required to be used, for the benefit of the primary care center;

2.11.2. The primary care center has transferred or may transfer resources to the subsidiary, foundation, related corporation, joint venture, or other similar organization;

2.11.3. The subsidiary, foundation, related corporation, joint venture, or other similar organization has transferred or may transfer resources to the primary care center, or any of the primary care center's resources are held for the benefit of the subsidiary, foundation, related corporation, joint venture, or other similar organization;

2.11.4. The primary care center has assigned certain of its functions to the subsidiary, foundation, related corporation, joint venture, or other similar organization, that is operating primarily for the benefit of the primary care center;

2.11.5. The subsidiary, foundation, related corporation, joint venture, or other similar organization is wholly owned or was created by the primary care center, and the primary care center receives any of the profits of the subsidiary, foundation, related corporation, joint venture, or other similar organization; or

2.11.6. The primary care center is wholly owned or was created by the foundation, related corporation, joint venture, or other similar organization, and the foundation, related corporation, joint

venture, or other similar organization receives any of the revenues of the primary care center.

2.12. "Rural Health Clinic" or "RHC" means a facility that:

2.12.1. Has been determined by the Secretary of the United States Department of Health and Human Services to meet the requirements of section 1861(aa)(2) of the United States Social Security Act, Title 42 U.S.C. § 1395x(aa)(2), and for certification for participation in Medicare; and

2.12.2. Has filed an agreement with the Secretary of the United States Department of Health and Human Services in order to provide rural health clinic services under Medicare. (See 42 CFR Part 405, Subpart X and 42 CFR Part 491 for additional information.)

2.13. "Secretary" means the Secretary of the Department of Health and Human Resources.

2.14. "Sliding Fee Scale" means a set of varying amounts (percentages of a maximum fee) to be charged for services to individuals receiving varying levels of income.

2.15. "Uncompensated Primary Care Costs" means a primary care center's financial deficit created when the primary care center's revenues do not offset expenses incurred in rendering primary care services.

§64-70-3. Primary Care Support Appropriation.

3.1. Upon the enactment and approval of an annual state budget that includes an appropriation dedicated to "primary care support," the Secretary shall designate a portion of such fund for transfer to the BMS medical services fund for use in the state Medicaid program; such amount so designated shall be in an amount that the Secretary, in his or her discretion and based on an assessment of the state's overall primary care needs, determines would be best dedicated to provide additional funding.

3.2. The portion of the annual appropriation remaining in the primary care support fund after the transfer to the BMS medical services fund in accordance with subsection 3.1 of this rule shall be disbursed by the director in accordance with the provisions of this rule, and may be expended to support activities related to rural and primary care and include, but not limited to, the following: Offset of costs of uncompensated care provided by primary care centers; technical support to and educational collaboration with the primary care centers; required cost-sharing and matching of key federal grants; and personnel and related administrative costs incurred by BPH in its operation of the program.

§64-70-4. Application Procedures.

4.1. Applications for grants to offset the cost of providing uncompensated primary care services shall be submitted by May 1 of each year, unless another date is announced by the director, and shall be on forms approved by the director. The director may request appropriate documentation or clarification of the application from the applicant.

§64-70-5. Eligibility.

5.1. In order to be eligible for a grant, an entity shall provide evidence that it:

5.1.1. Has been in existence for a period of at least two years or has requested certificate of need review at least two years prior to the date of the application;

5.1.2. Is incorporated under the laws of West Virginia as a private nonprofit corporation;

5.1.3. Has a community-based board of directors;

5.1.4. If it derives revenues, at least 80 percent of the revenues, excluding those funds from charitable foundations and state and federal grants, are derived from the provision of primary care services;

5.1.5. Provides full disclosure regarding all related organizations and their financial relationship to the primary care center;

5.1.6. Provides primary care services to all patients regardless of the patients' ability to pay; and

5.1.7. Uses generally accepted accounting principles.

§64-70-6. Application Reviews and Grant Awards.

6.1. Review of grant applications to offset costs of uncompensated care consists of the analysis and evaluation of the following information:

6.1.1. The organization's most recent audit as described in section 7 of this rule;

6.1.2. A 12 month period summary of revenues and expenses;

6.1.3. Projected grant year revenues and expenses;

6.1.4. Number of actual and projected patients and patient encounters;

6.1.5. Actual and projected collections;

6.1.6. Services provided;

6.1.7. Indebtedness;

6.1.8. Notice of federal grant awards;

6.1.9. Verification of quality assurance;

6.1.10. Evidence of historical receipt of funds as of July 1, 2019; and

6.1.11. Any other information judged necessary by the director to evaluate the organization's need for state funding.

6.2. The director shall base awards of grant funds on the grant application review and the availability of funds.

6.3. The grantee shall use grant funds only to support the delivery of uncompensated health care services.

6.4. The grantee shall not divert grant funds to any related or other organization.

6.5. The applicant will be notified in writing within 30 days of approval or denial of the grant. Approval or disapproval will be determined by the director, after recommendations have been made by the program staff.

6.6. The director may deny or revoke a grant, or take other available actions, if an applicant, a grantee, or an officer or principal owner of the applicant or grantee has been determined by an appropriate administrative agency or court to be in violation of any applicable federal, state, or local law, rule, or ordinance related to the provision of primary care services by the applicant or grantee.

§64-70-7. Audits.

7.1. A primary care center that has received a grant under this rule shall arrange to have an audit of its total entity for its annual fiscal period in accordance with 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards and in accordance with W. Va. Code §12-4-14. The primary care center shall furnish the director with two copies of the audit report within 120 days of the end of the primary care center's annual fiscal (audit) period. All questioned or disallowed costs identified in the audit that cannot be resolved to the director's, and if applicable, the appropriate federal granting agency's satisfaction shall be returned to the director no later than 180 days following the audit period. The primary care center shall retain audit work papers for a minimum of three years from the date of the audit report and shall make the audit work papers available upon request to the director as well as the appropriate federal granting agency.

7.2. In carrying out the requirements of section 7.1 of this rule, the primary care center shall not use the firm that prepares the organization's financial statements to conduct the annual independent audit. A grantee may request an exemption from the audit requirement from the director. The request shall be written and shall include justification for the exemption. The director may, at his or her discretion, grant the exemption.

§64-70-8. Administrative Due Process.

Those persons adversely affected by the enforcement of this rule desiring a contested case hearing to determine any rights, duties, interests, or privileges shall do so in a manner prescribed in the "Rules of Procedure for Contested Case Hearings and Declaratory Rulings," 64CSR1.