WEST VIRGINIA

SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #3

FILED

1990 JAN 22

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Department of Health and Human Resources TITLE NUMBER: 69

CITE AUTHORITY W. Va. Code §16-29D-7

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 2

TITLE OF RULE BEING PROPOSED: Implementation of Omnibus Health Care Act

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Taunja Willis Miller, Secretary

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Building 6, Capitol Complex
Charleston, WV 25305

Gaston Caperton
Governor

September 1, 1989

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, West Virginia 25305

Re: W.Va.C.S.R., Title 69, Series 2; Emergency Filing of Legislative Rule; Statement of Facts and Circumstances Constituting the Emergency; Written Approval.

Dear Secretary Hechler:

This letter is written to indicate my approval of the filing of this emergency legislative rule and of the filing of the proposed permanent legislative rule. In addition, this letter indicates the basis for the filing of this legislative rule on an emergency basis.

During the past legislative session, the Legislature adopted the Omnibus Health Care Act which has been codified at West Virginia Code §16- 29D-1 et seq. Section 7 of that Act provides that the "secretary of the department of health and human resources shall promulgate rules to carry out the provisions of this article." Additional rule making authority is granted to the secretary under West Virginia Code §5F-2-2(a)(11). Moreover, West Virginia Code §5F-2-2(a)(12) requires that the secretary grant his or her written approval before any rule can have any force or effect.

The Omnibus Health Care Act authorizes divisions and departments of state government to cooperate with each other "in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of such departments and divisions and to ensure the containment of costs in the payment for such services." West Virginia Code §16-29D-3(a). While some of the divisions or departments affected by this Act are within the Department of Health and Human Resources (e.g., Division of Health, Division of Human Services, Division of Workers' Compensation), others are located within other departments (e.g., Public Employees Insurance Agency and Division of Rehabilitation Services). However, the Secretary of the Department of Health and Human Resources is authorized to administer the cooperative actions of all of these agencies which are taken pursuant to the Omnibus Health Care Act.

Accordingly, in order to effectuate the purposes of the Act, the Department is today filing on an emergency basis a legislative rule titled "Implementation of Omnibus Health Care Act." We have designated this rule as Series 2 of Title 69.

We are also filing this rule as a proposed permanent legislative rule and have scheduled the required public hearing on the date indicated in the attached documentation.

The justification for filing this rule on an emergency basis rests upon two separate bases. First, West Virginia Code §16-29D-7 indicates that emergency rules may be used. Second, as an independent basis for filing this rule on an emergency basis, West Virginia Code §29A-3-13(a) provides that an agency may propose an emergency rule and subsection 13(g) provides that "an emergency exists when the promulgation of a rule is necessary for the immediate preservation of the public peace, health, safety or welfare or is necessary to comply with a time limitation established by this code or by a federal statute or regulation or to prevent, substantial harm to the public interest." Subsection 13(a) requires that the circumstances constituting the emergency be stated with particularity.

The Legislature made the Omnibus Health Care Act effective from passage. However, the various provisions of the Act do not become operational until the various departments and divisions of state government adopt a plan or plans of cooperation. Concurrently with the filing of this emergency rule, a plan of cooperation is also being adopted by the Department and affected divisions. In addition, another emergency rule is being filed concerning the adoption of a rate methodology for the Public Employees Insurance Agency. Upon the adoption of a plan, several conditions of participation contained in the Act become operative. One condition affects the ability of health care providers to bill state program beneficiaries for the balance of charges claimed by the provider over and beyond what the state program pays. Another condition requires that a health care provider which treats one program's beneficiaries cannot discriminate against the beneficiaries of another state health program and refuse to take such beneficiaries as patients simply because they are beneficiaries of that program. The Act allows providers to indicate their refusal to participate in all of the state programs. Also, the Act provides for penalties and a procedure for the Secretary to use for health care providers who violate the Act and the rules.

This emergency rule implements all of these provisions without which the Act cannot be administered. The Legislature found that a significant and ever-increasing portion of the State's resources are being expended for health care services and yet the State has been unable to timely pay for such health care services. It found that the Public Employees Insurance Agency and the State medicaid program face serious financial difficulties in terms of decreasing amounts of available federal and State dollars to fund the programs and for paying debts presently owed. The Legislature found that "it is in the best interest of the state and the citizens thereof that the various state departments and divisions involved in such provision of health care and the payment thereof cooperate in the effecting of cost savings." West Virginia Code §16-29D-1(a)(5). It also found that the "health and well being of all state citizens, and particularly those whose health care is provided or paid for by the [state programs] are of primary concern to the state." West Virginia Code §29D-1(a)(6).

The failure to implement the Act on an emergency basis will result in the defeat of the Legislative purposes espoused in the Act and would be detrimental to the health and well being of the state program beneficiaries. Without the provisions of this rule, state health care providers would be without guidance in deciding whether or not to continue participation in the state programs, would not know whether they were in compliance with the requirement not to discriminate against classes of state program beneficiaries, and would not know when their actions would bind them to the provisions of the Act despite their intentions to withdraw from participation. In addition, patients of withdrawing providers would not receive appropriate notices of the need to seek other health care providers and many patients may be left without access to the care that they need. In short, this rule is needed so that there can be an orderly transition to the enforcement of the Omnibus Health Care Act, so as not to jeopardize the health and well-being of patients who receive their health care through the affected state programs, and so as to give affected health care providers appropriate notice of the effects of the Act upon them and the procedures open to them under the Act.

If your office desire further information on the need for the emergency promulgation of this rule, please do not hesitate to contact me at your convenience.

Very truly yours,

Taunja Willis Miller
Secretary

TWM/jah

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Implementation of Omnibus Health Care Act

Type of Rule: X Legislative _____ Interpretive _____ Procedural

Agency: Department of Health and Human Resources

Address: Building 6
Capitol Complex
Charleston, WV 25305

1. Effect of Proposed Rule	ANNUAL Increase	ANNUAL Decrease	FISCAL YEAR Current	FISCAL YEAR Next	FISCAL YEAR Thereafter
Estimated Total Cost	$	$	$ 0	$ 0	$ 0
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

Monitoring of this rule will be accomplished by the existing personnel of the various state agencies conducting state beneficiary health care programs.

3. Objectives of these rules: The objective of this rule is to set forth the conditions of participation by health care providers in state beneficiary health care programs.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

This rule per se will have no economic impact on State government. The intent of the law to which this rule is related is to control the rising cost of State-supported health care programs.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

There may be minimal costs to providers associated with record-keeping they may wish to perform to document their compliance with this rule.

C. Economic Impact on Citizens/Public at Large.

None

Date September 1, 1989

Signature of Agency Head or Authorized Representative

Taunja Willis Miller, Secretary
Department of Health and Human Resources

DATE: January 22, 1990

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: Taunja Willis Miller, Secretary, Department of Health and Human Resources

LEGISLATIVE RULE TITLE: Implementation of Omnibus Health Care Act

1. Authorizing statute(s) citation W. Va. Code §16-29D-7

2. a. Date filed in State Register with Notice of Hearing:

September 1, 1989

b. What other notice, including advertising, did you give of the hearing?

Advertisements in Charleston newspapers and other newspapers across the State; notice mailed to all physicians in State.

c. Date of hearing (s): October 16, 1989

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received ____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

January 22, 1990

f. Name and phone number of agency person to contact for additional information:

David P. Lambert, General Counsel, Public Employees Insurance Agency. 348-2942.

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

   a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

      N/A

   b. Date of hearing: _____

   c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

      _____

   d. Attach findings and determinations and reasons:

      Attached _____

TITLE 69
LEGISLATIVE RULES
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 2
IMPLEMENTATION OF OMNIBUS HEALTH CARE ACT

§69-2-1. General

1.1. Scope - This emergency legislative rule implements the provisions of the Omnibus Health Care Act, West Virginia Code, §16-29D-1 et seq., 1989. Under the Act, the Secretary of the Department of Health and Human Resources is charged with the responsibility of promulgating rules to carry out the provisions of the Act. The agencies subordinate to the Secretary under the provisions of the Act and to whom this rule is applicable are the Division of Health, the Division of Human Services, the Division of Employment Security, and the Division of Workers' Compensation. In addition, section 3 of the Act specifies that certain entities not within the Department of Health and Human Resources are also subject to the provisions of the Act and of this rule. Those other entities are the Public Employees Insurance Agency within the Department of Administration, the Division of Rehabilitation Services under the State Board of Education sitting as the State Board of Rehabilitation, and the Board of Trustees, which has responsibility for the state's medical schools, within the Department of Education and the Arts. All of these governmental entities either are involved in provision of health care services to beneficiaries of their programs or pay for health care services delivered to those beneficiaries, or both, as well as often providing many other services to the beneficiaries of those governmental entities' programs.

1.2. Authority - West Virginia Code, §16-29D-7.

1.3. Related Rules - This emergency legislative rule is distinct from, but is to be read in conjunction with, other rules to be promulgated under the authority of West Virginia Code, §16-29D-7. One such rule will relate to procedures for administrative hearings; others will relate to payment for medical services by the departments and divisions subject to the Act.

1.4. Filing Date - September 1, 1989.

1.5. Effective Date - September 1, 1989.

§69-2-2. Definitions

2.1. As used in this emergency legislative rule, the following terms, words, and phrases have the meanings stated below unless in any instance where such term, word, or phrase is employed the context clearly indicates that another meaning is intended.

2.2. The term "Act" means the Omnibus Health Care Act which is codified at article 29D, chapter 16 of the Code of West Virginia of 1931, as amended.

2.3. The terms "Code of West Virginia" and "West Virginia Code" mean the West Virginia Code of 1931, as amended.

2.4. The term "coordination of benefits" means a provision which establishes an order in which two or more insurance contracts, plans or programs covering the same beneficiary pay their claims, with the effect that there is no duplication of benefits.

2.5. The terms "health care," "health care services," or "health care treatments" mean clinically related preventive, diagnostic, treatment, or rehabilitative services whether provided in the home, office, hospital, clinic or any other suitable place either inside or outside the state of West Virginia provided or prescribed by any health care provider or providers. Such services include, among others, medical supplies, appliances, laboratory, preventive, diagnostic, therapeutic and rehabilitative services, hospital care, nursing home and convalescent care, medical physicians, osteopathic physicians, chiropractors, and such other surgical including inpatient oral surgery, nursing, and podiatric services and supplies as may be prescribed by such health care providers but not other dental services.

2.6. The term "health care provider" means a person, partnership, corporation, facility or institution licensed, certified or authorized by law to provide professional health care services in or outside this state to an individual during this individual's medical care, treatment or confinement. For the sole purpose of this rule and the implementation of the Act, the term does not include pharmacists and pharmacies. At the option of a medical corporation, evidenced by the filing of a statement with the director of the Public Employees Insurance Agency and the assignment of separate provider numbers by the state departments and divisions paying for health care services under the provisions of the Act, each individual providing professional health care services within such corporation shall be considered as a separate health care provider.

2.7. The term "life-threatening medical or surgical emergency" shall include an emergency posing an imminent threat of significant, permanent and clearly recognizable bodily impairment such as blindness or loss of limb.

2.8. The term "this rule" means the present emergency legislative rule which has been designated as Title 69, Series 2.

2.9. The term "the Secretary" means the Secretary of the Department of Health and Human Resources.

§69-2-3. Purpose

3.1. The purpose of this rule is to implement the Act. In adopting the Act, the Legislature stated that it intended "to provide a framework within which the departments and divisions of state government can cooperate to effect cost savings for the provision of health care services and the payment thereof. It is the purpose of the Legislature to encourage the long-term, well-planned development of fair, equitable and cost-effective systems for all health care providers paid or reimbursed by the public employees insurance agency, the state medicaid program, the workers' compensation fund or the division of rehabilitation services." West Virginia Code, §16-29D-1(b). This same purpose is applicable to the Division of Health.

3.2. In order to achieve this purpose, the Legislature directed that the state must ensure the delivery of high quality health care services and effect cost savings in the provision of health care services. The Legislature concluded that it is in the best interests of the state and its citizens for the various state departments and divisions, including the state's medical schools, which are involved in the provision of health care services and the payment thereof, to cooperate in the generation of cost savings and in ensuring the quality of the health care services delivered to the beneficiaries of all the state-supported programs.

§69-2-4. Non-Interference with the Medicaid Program

It is expressly recognized that no other entity may interfere with the discretion and judgment given to the single state agency which administers the state's medicaid program. Thus, it is the intention of this rule that nothing contained herein shall be interpreted, construed, or applied to interfere with the powers and actions of the single state agency which, in keeping with applicable federal law, shall administer the state's medicaid program as it perceives to be in the best interest of that program and its beneficiaries.

§69-2-5. Condition of Participation - Other Program Patients

5.1. In order to assure and to increase access to quality health care services for all state program beneficiaries, and in particular the state's medicaid beneficiaries, the Act requires that any health care provider who agrees to deliver health care services to any beneficiary of a health care program of any one or more of the departments or divisions of the state, the charges for which shall be paid or reimbursed by such department or division, also not refuse to take the beneficiaries of another state program because they are beneficiaries of that other program and would have their health care services paid for under that other program. However, the health care provider retains his or her or its rights to refuse to accept any patients for reasons not related to their status as beneficiaries of such other program. Examples of such unrelated reasons are that the health care provider is not taking any new patients, that the health care provider accepts patients only upon referral and the beneficiary has not been referred, that the health care provider does not practice in the field of health care service specifically needed by the beneficiary, that the beneficiary does not require the health care services

requested, that the beneficiary is an uncooperative patient which fact is known to the health care provider through the provider's own personal knowledge and experience, and similar non-discriminatory reasons.

5.2. With the exceptions noted below in subsection 5.4, any health care provider who agrees to provide covered health care services to any beneficiary of a state program shall also be deemed to agree to take as patients for covered services the beneficiaries of all other state programs. Refusal to take a particular beneficiary or class of beneficiaries because, in whole or in part, the individual or class of individuals are participants in a particular state program shall cause the health care provider to be in violation of the Act and this rule.

5.3. A health care provider will be presumptively in compliance with the provisions of subsection 5.2 of this rule, if

5.3.1. The health care provider actually delivers covered health care services to all such beneficiaries who request such services or refuses only for reasons not related to such persons' status as beneficiaries as provided in section 5.1; or

5.3.2. With respect to beneficiaries of the state's medicaid program, the health care provider actually delivers health care services to a sufficient number of patients who are beneficiaries of the state's medicaid program to equate to at least fifteen (15) percent of the health care provider's total active patient population. An active patient is one to whom the health care provider has delivered health care services within the two years preceding the date on which the determination is being made. For those health care providers who practice in both obstetrics and gynecology, such a provider will be presumptively in compliance with respect to beneficiaries of the state's medicaid program if the provider actually delivers covered health care services to all such beneficiaries who request obstetric services, or to at least a sufficient number of such beneficiaries to equate to at least fifteen (15) percent of the provider's total active obstetric patient population and, if the provider actually delivers covered health care services to all such beneficiaries who request gynecological services, or to at least a sufficient number of such beneficiaries to equate to at least fifteen (15) percent of the provider's total active gynecological patients.

5.3.2.1. In making a determination of the sufficient number of patients who are beneficiaries of the state's medicaid program to equate to at least fifteen (15) percent, nothing in this rule should be construed as requiring the provider to cease delivering health care services to patients who are beneficiaries of other states' medicaid programs. Provided, however, that in determining presumptive compliance under subsection 5.3.2 of these rules, a sufficient number of patients who are beneficiaries of the state's medicaid program will be equated to at least fifteen (15) percent of the provider's active patients who are state residents. Provided, however, that the provider does not refuse to take beneficiaries of this state's medicaid program as his or her practice admits appropriate new patients. Provided further that the provider does not discriminate in accepting patients in favor of beneficiaries

of another state's medicaid program and against beneficiaries of this state's medicaid program because of differing rates of reimbursement.

5.3.3. With respect to beneficiaries of the state's medicaid program, the health care provider expends a substantial amount of his, her or its actual practice time, equal to approximately fifteen (15) percent, providing services to patients who are beneficiaries of the state's medicaid program, or other programs recognized by the Secretary as serving indigent citizens of the state, either in the provider's own practice or facility, or in practice settings or sites which are operated or organized by the state or federal government or not-for-profit corporations, organizations or agencies, or some combination of both. Full-time and clinical faculty of teaching programs recognized by the Secretary as serving indigent citizens of the state may count toward the fifteen (15) percent practice time hours spent either directly providing patient care in connection with such program or time spent assisting, consulting with, supervising or training students in the actual provision of such patient care.

5.3.4. For purposes of determining compliance with the provisions of subsection 5.2 of this rule, a provider will receive credit for good faith efforts to schedule appointments for state program beneficiaries, including beneficiaries of the state's medicaid program or other indigent care programs recognized by the Secretary pursuant to subsection 5.3.3 of this rule, regardless of whether or not the prospective patient actually appears for the appointment.

5.4. The implied agreement set forth in subsection 5.2 shall not arise in the following circumstances:

5.4.1. When the health care provider delivers health care services to a state program beneficiary which are immediately needed to resolve an imminent life-threatening medical or surgical emergency; however, once the disease or injury which caused the emergency is stabilized, then further treatment of that beneficiary by the health care provider will give rise to the implied agreement. Provided, however that the health care provider must be willing to deliver health care services to any state program beneficiary which are immediately needed to resolve an imminent life threatening medical or surgical emergency, until the disease or injury which caused the emergency is stabilized. For the purpose of this subsection, stabilize means resolved or no longer requiring treatment for the specific occurrence; or

5.4.2. When a physician who is on the staff of a hospital or other health care facility and who as part of his or her duties as an on-call staff physician must deliver health care services to persons who present themselves at the facility, then if any such person is a beneficiary of a state program the implied agreement set forth in subsection 5.2 will not arise as a result of the health care provider's delivering health care services and all necessary follow-up services to that beneficiary. Provided, that the health care provider must deliver health care services as such on-call staff physician and all necessary follow-up services to the beneficiaries of any state program presenting themselves at the facility. However, if the health care provider

delivers health care services to that beneficiary for an unrelated condition as part of the health care provider's private practice, then the implied agreement will arise. An example of this sub-subsection is a physician who is on the staff of a hospital which has medical staff bylaws requiring all physicians to take turns in the hospital's emergency room and to treat all persons who present themselves for health care services at that emergency room. The treatment of a state program beneficiary who comes to the emergency room by a physician and the provision of all necessary follow-up services will not obligate that physician to deliver health care services to other state program beneficiaries. But, if the physician elects to treat that beneficiary for unrelated conditions in the physician's private office, then the implied agreement to treat other state program beneficiaries will arise at the time the unrelated treatment is provided.

5.4.3. When a health care provider who has agreed to serve state program beneficiaries requires the services of another provider (e.g., for coverage, consultation, second opinion, or assistance with a procedure), in connection with the treatment of a state program beneficiary or beneficiaries, and cannot locate to perform such service another provider who has agreed to serve state program beneficiaries, then the provider in need may request a provider who has withdrawn pursuant to section 6 of this rule to perform the needed service. Provision of such service in good faith by a provider who has withdrawn shall not subject the provider to the implied agreement set forth in subsection 5.2 of this rule. Moreover, such provider may be paid by the appropriate state program, if the provider who requested the service either obtains precertification authorization for the service from the state agency or submits, promptly after the service has been rendered, a brief written statement to the state agency explaining why the services of a withdrawn provider were utilized. Such statement shall describe what efforts were made to locate a non-withdrawn provider; provided, however, that such efforts shall not be required in an emergency situation, whether life-threatening, or otherwise. If a health care provider who serves state program beneficiaries will require the services of a withdrawn provider on an ongoing, periodic or repeat basis (e.g., for coverage), the provider shall request in writing from the director of the Public Employees Insurance Agency an exception which will authorize the withdrawn provider to provide the required service and be paid by the appropriate state agency, without subjecting the provider to the implied agreement set forth in subsectin 5.2 of this rule. The director of the Public Employees Insurance Agency may approve such request if the director finds that the service is not reasonably available from a provider who is serving state program beneficiaries, or for other good cause.

§69-2-6. Withdrawal by Health Care Providers from Participation

6.1. A health care provider may withdraw from providing health care services to beneficiaries of the health care programs of the departments and divisions of the state pursuant to a plan or plans developed in accordance with the Act. Any health care provider, who provided health care services to a beneficiary of any state health care program on or after April 8, 1989, the effective date of the Act, and who decides that he, she, or it does not wish to continue to serve beneficiaries of state health care programs under the new terms imposed by the Act, must withdraw by following the procedures set forth in

this rule, in order to avoid being subject to the implied agreement set forth in subsection 5.2 of this rule. In order to effect the withdrawal, the health care provider shall provide a written notice to the director of the Public Employees Insurance Agency which shall state that the provider intends to withdraw from participation in such plan or plans. The effective date of withdrawal for the purposes of this rule shall be the date of receipt of the written notice by the director of the Public Employees Insurance Agency. The written notice shall be sent to the director of the Public Employees Insurance Agency by certified mail, return receipt requested. The notice shall identify the health care provider by name, by FEIN (tax) number, and by address and telephone number. It is recognized that some providers in good faith believed that if they ceased treating state program beneficiaries before the Plan and rules implementing the Act were filed, then they would not need to withdraw formally by sending written notice to the director of the Public Employees Insurance Agency as provided in this rule. However, requiring such written notice is the only way the state, other providers, and beneficiaries can all be informed as to which providers are treating state beneficiaries and which are not. Accordingly, those providers who believed they withdrew without sending the written notice are required by this rule to send the notice; however, these providers will not be deemed to have been in violation of the Act and will suffer no adverse consequences. In addition, a few health care providers may never have delivered health care services to state health program beneficiaries and are thus technically not required by the Act or this rule to withdraw formally if they wish to continue not seeing state beneficiaries. However, any such providers are nonetheless encouraged to provide the written notice, again so that no confusion will exist as to which providers are treating state beneficiaries and which are not.

6.2. As a general rule, the health care provider shall have forty-five (45) days from the effective date of the provider's withdrawal within which to cease continued treatment of the provider's patients who are state program beneficiaries. Not later than ten (10) days after the effective date of withdrawal, the withdrawing provider shall give his, her or its state program beneficiary patients who are under active treatment written notice of such provider's withdrawal, to enable these patients to arrange for care by other providers. Failure by the provider to deliver the notice to a patient within the ten (10) day period shall render the provider's charge for any health care services delivered beyond the forty-five (45) day period null and void and they shall not be recoverable from either the beneficiary or the state division or department. Exceptions to this general rule are stated below. During the forty-five (45) day period, the health care provider may continue to provide health care services to state program beneficiaries who were patients of the provider prior to the effective date of the provider's withdrawal. With the exceptions noted in subsection 5.4, within the aforesaid forty-five (45) day period the provider may not undertake the initial delivery of health care services to state program beneficiaries who were not patients of the provider prior to the date of receipt of the provider's withdrawal notice by the director of the Public Employees Insurance Agency or who had not been seen by the provider for the actual delivery of health care services for a period of two (2) years prior to such date of receipt. The delivery of health care services during the forty-five (45) day period to such pre-established patients shall not obligate the health care provider to deliver health care services to other state program beneficiaries.

6.3. As exceptions to the general rule stated in subsection 6.2 of this rule, the health care provider may elect to continue to treat individual state program beneficiaries who he, she or it is treating as of the effective date of ~~this rule~~ the withdrawal in the following specific categories without obligating the provider to undertake the delivery of health care services to state program beneficiaries. However, nothing in this subsection shall permit the health care provider to continue to provide health care services beyond the forty-five (45) day period described in subsections 6.1 and 6.2 to previously established state program beneficiaries who do not come within the following specific categories of patients or permit the provider to accept new state program beneficiaries as patients after the effective date of his, her or its withdrawal. The purpose of these exceptions is to ensure the continued access by state program beneficiaries to quality health care services in these special situations. ~~during the transitional period for implementation of the~~ Act.

6.3.1. An obstetrical patient for whom the health care provider has been providing prenatal care. In this event, the health care provider may continue to deliver health care services to the patient until the outcome of the pregnancy and after the completion of customary medical follow-up health care. The health care provider shall file a statement with the director of the Public Employees Insurance Agency identifying the provider by name, FEIN (tax) number, address and telephone number, and identifying any such patients by name, address, and social security number.

6.3.2. A patient whose condition places him within a risk of suffering serious and permanent harm if such patient has been unable, after good faith efforts, to secure a health care provider of equivalent training. In this event, the health care provider may continue to deliver health care services to the patient until the risk of suffering serious and permanent harm has abated or the patient can obtain care from a health care provider of equivalent training. The health care provider shall file a statement with the director of the Public Employees Insurance Agency which shall identify the provider by name, FEIN (tax) number, address and telephone number and identify the patient by name, address, social security number and, in the case of a beneficiary of the Division of Workers' Compensation, claim number. The statement shall give the history, diagnosis, and prognosis for the patient and such other information as the health care provider believes will best describe the patient's condition and shall include documented medical records.

6.3.3. A patient who, despite good faith efforts, has been unable to secure a replacement health care provider of equivalent training and who receives permission from the director of the Public Employees Insurance Agency to continue to receive health care services from the patient's withdrawing health care provider after the expiration of the forty-five (45) day period. Either the patient or the health care provider may petition the director of the Public Employees Insurance Agency for such permission. The petition shall be accompanied by a statement from the provider identifying any conditions which may require ongoing medical attention and indicating the provider's willingness to continue to provide health care services to that beneficiary. Further, the petition shall state in detail the efforts made by the patient or

others on the patient's behalf to secure an equivalently trained health care provider and the reasons for the failure of those efforts. The director of the Public Employees Insurance Agency may exercise his or her discretion to grant a waiver to the patient upon being satisfied that there have been good faith efforts made to locate an equivalently trained health care provider, that those efforts have failed for reasons beyond the control of the patient or others working on behalf of the patient or of the health care provider, and that continued treatment by the health care provider is reasonably necessary for the health and well being of the patient.

6.3.4. In any case where a health care provider has been delivering health care services to a patient whose condition is expected to be terminal, the health care provider may continue such patient's treatment upon obtaining permission from the director of the Public Employees Insurance Agency. In order for the patient or the health care provider to avail himself, herself, or itself of this exception, either the patient, the patient's family member or the provider shall file a petition with the director of the Public Employees Insurance Agency requesting permission to continue the treatment. The petition shall be accompanied by a statement from the provider, setting forth the provider's reasons for believing that the patient's condition is terminal. Upon being satisfied that the facts stated in the petition are correct and that the opinions stated therein are reasonable and based upon the asserted facts, the director of the Public Employees Insurance Agency may permit the health care provider to continue the delivery of health care services to that particular patient.

6.3.5. In any other case, either the patient or the health care provider may petition the director of the Public Employees Insurance Agency for permission for the withdrawing health care provider to continue the delivery of health care service to a particular patient. The petition shall state in detail the facts and arguments relied upon by the petitioner for the relief requested. The director of the Public Employees Insurance Agency shall have the discretionary power to grant or refuse the relief requested. In exercising his or her discretion, the director shall consider the access to quality health care otherwise available to the patient, the nature of the injury, condition, or disease from which the patient suffers, the threat posed to the patient from that injury, condition, or disease in the absence of access to quality health care, and such other factors as may appear to the director to warrant the granting or denying of the relief requested. The director shall respond to all petitions filed pursuant to subsection 6.3 of this rule in a timely manner. No provider or beneficiary shall be penalized during the period in which he or she is awaiting the director's response, provided the petition was filed in good faith and on a timely basis.

6.3.6. In any case where the director of the Public Employees Insurance Agency denies the relief requested in a petition filed under this subsection 6.3 or rejects the continued treatment by the health care provider of the patient under sub-subsections 6.3.1 or 6.3.2 for beyond the forty-five (45) day period described in subsections 6.1 and 6.2 either the patient or the health care provider may appeal the director's determination by filing with the Secretary a

request for an administrative hearing. At the hearing, the burden of proof on all pertinent issues shall be upon the person requesting the hearing. The hearing shall be conducted in accordance with the Administrative Procedures Act, West Virginia Code, §29A-5-1 et seq., and applicable procedural rules promulgated by the Secretary.

6.4. Nothing in this section shall prohibit a beneficiary of a state program from seeking health care services from any provider of his or her own choosing. However, if that provider has elected to withdraw, in accordance with section 6 of this rule, from providing health care services to beneficiaries of the health care programs of departments or divisions of the state pursuant of the Act and this rule, then the cost of health care services received from such withdrawn provider will not be considered a covered service within the meaning of section 4(a) of the Act and will not be paid for by any state department, division or agency in accordance with the Act, whether as a primary or secondary payor of health care services for said beneficiary. This exclusion applies only to the services actually rendered by the withdrawn provider. If the withdrawn provider treats the patient in a hospital or other facility, the hospital charges and other services rendered and charged for separately by other providers (e.g., anesthesiology, laboratory work) will not be excluded merely because they were ordered by a withdrawn provider, unless the provider actually providing and charging for the service is also a withdrawn provider.

6.4.1. A provider delivering health care services and a beneficiary seeking health care services under this subsection 6.4 must both complete and sign a waiver, provided by the director of the Public Employees Insurance Agency, releasing all state programs or plans of any responsibility for payment of the services delivered through or by this private physician-patient agreement.

6.5. Out-of-state health care providers who refuse to provide covered health care services to any class of beneficiaries of a state health care program may be presumed to have withdrawn from providing health care services to beneficiaries of all state programs in the state plan or plans developed in accordance with the Act. In such instance, the Secretary or his or her designee may formally communicate with such out-of-state provider to determine whether the provider intends to comply with the Act, this rule, and any applicable plan, order or directive. If the provider refuses to so comply, or refuses to state clearly its position, then the Secretary or his or her designee may deem the provider to be a withdrawn provider, and any further services provided by such provider will be considered under section 6 of this rule.

§69-2-7. Testimony By Providers

Nothing in this rule or in the Act shall be deemed to prohibit a health care provider who has elected not to participate in the provision of health care services to state program beneficiaries (but who may have provided covered services to such beneficiaries prior to such election) from testifying on behalf of or against a state program beneficiary in any administrative or judicial proceeding. Divisions or agencies which otherwise have the responsibility of reimbursing such health care providers for the time expended

by the provider in so testifying shall continue to do so notwithstanding any other provision of this rule or the Act. Further, such testimony shall not obligate any health care provider who has previously elected not to participate in the delivery of health care services to state program beneficiaries to begin the delivery of such services.

§69-2-8. Violations and Show Cause Proceedings; Penalties

8.1. In the event that any health care provider or other legal entity violates any provision of the Act, of this rule, of any other rule duly promulgated by the Secretary under the provisions of the Act, or any plan, order, or directive issued under the provisions of the Act or any such rule, then the Secretary may assess a civil penalty ~~for each such violation~~ as provided by the Act and may order that the health care provider be removed from any list of providers for whose services a department or division may pay in the future.

8.2. Upon determining that there is probable cause to believe that a health care provider or other legal entity may be knowingly engaging in such a violation, the Secretary shall provide such health care provider or other legal entity with written notice which shall state the nature of the alleged violation and the time and place at which such health care provider or other legal entity shall appear to show cause why a civil penalty or removal from any list, or both, should not be imposed. Nothing in this rule shall limit the Secretary's authority to resolve informally any alleged violation, by such means as stipulation, agreed settlement, consent order, default, or other appropriate action.

8.2.1. For the purposes of violation of section 5 of this rule, a finding of probable cause shall be based upon a pattern of incidents in which beneficiaries of one or more particular programs have been denied health care services by a provider or an agent acting on behalf of the provider. Isolated first person reports or report by others that a person was denied health care services will not be a basis for a finding of probable cause, unless other corroborative evidence is received.

8.3. At the hearing so noticed, the Secretary shall arrange to have the evidence in support of the allegations presented and shall afford the health care provider or other legal entity an opportunity to cross-examine the state's witnesses and shall afford the health care provider or other legal entity an opportunity to present testimony and enter evidence in support of its position. The State shall bear the burden of proving a violation of the Act.

8.5. The hearing shall be conducted in accordance with the administrative hearings provisions of West Virginia Code, §29A-5-1 et seq., and applicable procedural rules promulgated by the Secretary.

8.6. If, after reviewing the record of such hearing, the Secretary determines, by a preponderance of the evidence, that such health care provider is in violation of the Act, of this rule, or any other rule promulgated under the Act, or any plan, order, or directive issued under the Act or such rule,

the Secretary may assess a civil penalty as provided by the Act ~~of not less than one thousand dollars not more than twenty-five thousand dollars~~ and may remove a health care provider from any list. In exercising his or her discretion in fixing the amount of the penalty as well as whether to remove a health care provider from a list, the Secretary shall be guided by the degree of willfulness shown in the violation, the nature and type of the violation, the monetary amount involved and whether the health care provider or other legal entity had personally gained by the violation, the degree of harm, if any, suffered by a beneficiary of any state supported program due to the violation, and such other factors as may appear in a particular case.

8.7. Any health care provider or other legal entity proceeded against under this section 8 shall receive notice in writing by certified mail of the decision, which decision shall contain a statement of the penalty imposed, if any, whether the health care provider is to be removed from any applicable list and the Secretary's findings of fact and conclusions of law in support of the exercise of the Secretary's discretion in the manner stated. The penalty and the removal may be imposed immediately by the Secretary without regard to whether or not an appeal is filed; however, the Secretary, in his or her discretion, may grant a stay of enforcement or collection of the penalty or removal pending the resolution of an appeal.

8.8. As provided for by West Virginia Code, §16-29D-8, the health care provider or other legal entity may appeal the Secretary's decision. Any such appeal shall be taken and be handled in accordance with West Virginia Code, §29A-5-4. The circuit court's review shall include a review of the amount of the penalty and any removal of a health care provider. The circuit court may enter a stay against the collection or enforcement of any penalty or removal order after a hearing on the request for stay; however, such hearing may not be conducted on an ex parte basis.

8.9. If the health care provider or other legal entity penalized or ordered removed either loses on appeal or has not appealed such penalties or removal and fails to pay the amount of the penalty to the Secretary within thirty days or if the health care provider continues to act in a manner contrary to his or her or its removal, the Attorney General may institute a civil action in the circuit court of Kanawha County to recover the amount of the penalty or to seek an injunction. Such civil action shall be handled in an expedited manner by the circuit court and shall be assigned for hearing at the earliest possible date.

8.10. The remedies set forth in this section are intended only for violations of the Act and shall not affect any other contractual relationship between any department or division and a health care provider or other legal entity.

8.11. Any health care provider removed from a list pursuant to this section 8 may petition the Secretary for reinstatement to such list after one-hundred and eighty (180) days from his removal. Any appeal by the provider of the Secretary's decision shall be taken and handled in accordance with West Virginia Code, §29A-5-4.

8.12 Any patient-identifying information or records obtained by the Secretary or his or her employees or agents, or by any other department or division subject to the Act, during any investigation or enforcement of the Act, this rule, or any other rule duly promulgated by the Secretary under the provisions of the Act, shall be kept confidential and shall not be released to the public. If the Secretary receives allegations that a provider is not in compliance with subsection 5.2 of this rule, then before the Secretary may subpoena patient-identifying records or information, the Secretary shall first afford the provider an opportunity to submit a verified statement from the provider's office manager, accountant or other similar person, attesting to: (1) the total number of state medicaid beneficiaries (including patients of other indigent programs recognized pursuant to subsection 5.3.3 of this rule) to which the provider has delivered (or scheduled for) health care services during a time period agreed to by the Secretary; and (2) the total number of patients who are State residents to which the provider has delivered (or scheduled for) health care services during this same period. The statement shall also explain in detail how these patient totals were derived. If the statement indicates that the provider in question has delivered (or scheduled for) health care services to a sufficient number of patients who are state medicaid beneficiaries (including patients of indigent programs recognized pursuant to subsection 5.3.3 of this rule) to equate to at least fifteen (15) percent of the total number of patients who are State residents to when the provider has delivered (or scheduled for) health care services during the same period, then the Secretary may not subpoena patient-identifying records or information unless the Secretary has reasonable cause to question the accuracy of the statement submitted by the provider or for other reasonable cause. Nothing in this section shall prohibit the Secretary from obtaining at any time patient-identifying records or information if the patient has consented to their release.

§69-2-9. Declaratory Rulings and Informal Opinions

If in any particular instance a health care provider wishes to request that the Secretary make a determination of the applicability of any section of this rule, or of any exception contained therein, to a given state of facts, the health care provider may request either an informal opinion or a declaratory ruling from the Secretary in accordance with the provisions of West Virginia Code, §29A-4-1.

§69-2-10. Severability

If any provision of this rule or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not affect the provisions or the applications of this rule which can be given effect without the invalid provisions or application, and to this end the provisions of this rule are declared to be severable.

SUMMARY OF PUBLIC COMMENT

Title 69, Series 2 "Implementation Of Omnibus Health Care Act."

Commenter		Comment	Action
Derrick Latos President, WV State Medical Association	1.	Believes if State reviews list of physician's patients to verify 15% Medicaid guideline, will constitute invasion of physician's and patients' privacy. 15% standard should be applied only to provider's State program patients (i.e., not private patients).	Add a new §8.12, stating that any patient-identifying information obtained by the Secretary during the course of investigation or enforcement of Act or rules shall be kept confidential; also state that Secretary will give provider opportunity to verify compliance with 15% Medicaid guideline by having his or her office manager submit a statement showing numbers of patients seen. Secretary may subpoena patient information only if he or she has reasonable cause to question accuracy of statement.
	2.	§5.4 should be expanded to allow a non-participating physician to provide emergency or on-call coverage for a participating physician.	Add a new §5.4.3, stating that when a provider requires the services of another provider, for coverage, consultation, second opinion, assistance with a procedure, etc., whether in an emergency or otherwise, and provider cannot locate to perform the service another provider who is serving State patients, the provider may utilize a withdrawn provider. The withdrawn provider may be paid by the

Commenter	Comment	Action
		State and will not be subject to the obligation to treat all State beneficiaries if the provider requesting the assistance either precertifies the service or sends a brief statement to the appropriate State agency explaining why the services of a withdrawn provider were required.
	3. §69-2-6 ignores fact that there are two classes of non-participating providers: those who participate and then withdraw, and those who never participated. Subsections 6.1, 6.3 and 6.4 should be amended to clarify that only a provider who participates then elects to withdraw needs to send written notice to PEIA Director.	Don't do. Instead, amend §69-2-6 to clarify that a provider who served any State program beneficiaries on effective date of Act (April 8, 1989) can withdraw only by sending required notice to PEIA. Providers who believed they need not send written notice will not be considered to be in violation of the Act, but must send notice; this is only way the State, other providers, and patients can know which providers are serving State beneficiaries and which are not.
	4. Add word "further" in second sentence of §6.1 to read "from further participation," to make clear that a provider who never participated need not withdraw.	Don't do, for reasons stated in response to Comment #3.
	5. Amend §6.1 to permit a provider to specify the effective date of withdrawal, not limit to date of receipt by PEIA Director of notice of withdrawal.	Don't do. Provider can control when withdrawal date will be by when he, she or it sends in notice. Nothing in rules

Commenter	Comment	Action
		would prevent provider from notifying patients weeks or months in advance of actual withdrawal date of provider's decision to withdraw.
	6. Amend §6.3 to read "...who he, she, it is treating as of the effective date of the withdrawal," not "the effective date of this rule...."	Do.
	7. Amend §6.3, last sentence, to delete phrase "during the transitional period for implementation of the Act."	Do. Amend sentence to to read: The purpose of these exceptions is to ensure the continued access by State program beneficiaries to quality health care services in these special situations."
	8. Amend §6.3 to include, in addition to providers who have withdrawn, providers who never participated in serving State program beneficiaries.	Don't do, for reasons stated in response to Comment 3.
	9. Amend §8.1 to limit possible imposition of civil penalties to one penalty, of from $1,000 to $25,000 per hearing, not per violation, as currently indicated.	Because range of penalties is already stated in the law, simply delete reference in rules; court must ultimately resolve differing interpretations.
	10. Some form of guidance, in this rule or another form, needs to be given to providers on proper PEIA billing procedures.	Don't include in this rule. Separate informational mailings by PEIA to providers forthcoming.
	11. Question about calculating compliance with 15% Medicaid guideline. Many Medicaid patients who are scheduled for appointments do not appear.	Add new §5.3.4 to state that in measuring compliance, provider to be given credit for good

Commenter		Comment	Action
			faith efforts to schedule State beneficiaries, regardless of whether patient appears.
	12.	Will PEIA pay as secondary coverage for care provided by withdrawn provider?	No need for change. §6.4 clearly states that State will not pay for care by withdrawn provider, either as primary or secondary payor.
Ahmed D. Faheem, M.D.	1.	PEIA benefit of $25 for outpatient psychiatric care treats psychiatrists differently from other physicians, does not distinguish between first or second visit, whether care provided by M.D. or psychologist. State patients mistakenly believe they do not have to pay balance.	Comments address PEIA benefits, not Omnibus Act rules. PEIA is developing new mental health plan, comments will be considered in that context.
	2.	Community behavioral health centers that treat Medicaid patients receive higher reimbursement, through contracts with the State, than private practitioners; should be equalized.	Same as response to Dr. Faheem's Comment #1.
	3.	PEIA 90-day lifetime benefit for inpatient alcohol and drug treatment is too low.	Same as response to Dr. Faheem's Comment #1.
	4.	Repeats Dr. Latos' concerns about protecting confidentiality of patient information when verifying compliance with 15% Medicaid guideline.	See response to Dr. Latos' Comment #1.
Theodore P. Werblin, M.D.	1.	§6.4 should be amended to state that State beneficiary who is treated by withdrawn provider will pay 10-15% penalty, not 100% of costs.	Cannot do. Omnibus Act sets forth conditions of participation. If not followed by provider, State cannot pay.
	2.	§5.4.2 should be amended to provide some flexibility when a participating provider	See response to Dr. Latos' Comment #2.

Commenter	Comment	Action
	needs a consultation immediately from a non-participating provider. Providers need to be furnished current list of participating providers.	
3.	§5.3.2.1 should be amended to give credit toward compliance with 15% Medicaid guideline for care given by provider to any indigent patients.	Don't do. Rules already already broaden statutory language which seeks to ensure access by W. Va. Medicaid patients.
4.	§8.2 should permit Secretary of Health and Human Resources to require a written response from provider regarding alleged violation, rather than require hearing in all cases.	Add language to §8.2 to permit Secretary, consistent with State Administrative Procedures Act, to informally dispose of alleged violations.
5.	State has conducted no survey to deterine how many physicians are not participating. "Take one take all" limits access to care because provider unhappy with one program (e.g., Workers' Compensation) cannot serve beneficiaries of other programs	Requiring all non-participating providers to withdraw will give accurate total count non-participants. "Take one take all" is requirement of Act, cannot be modified in rules.
6.	Limiting reimbursement under Act will cause physicians to leave State. Alternative course would be to generate savings by "grading the health care delivery system to levels appropriate for different beneficiaries."	Not proposed changes to rules. Requires Legislative or other administrative action.

Commenter		Comment	Action
Berma L. Perfater, Teacher	1.	Personal physician, specialist in treatment of infertility, has withdrawn. Other specialists aren't taking new PEIA patients. PEIA patients. PEIA should set limit on amount it will pay to non-participating providers, allow patient to pay difference.	No new action. Current §§6.3.2, 6.3.3, 6.3.5 would permit exception, allowing commenter to to continue with current physician if equivalent care unavailable. State, by terms of Omnibus Act, cannot pay non-participating providers.
Perry Bryant, W. Va. Education Association	1.	Amend §5.3.2.1 to allow providers to count out-of-state Medicaid patients toward meeting 15% Medicaid guideline.	Don't do. Current language measures % of W. Va. Medicaid patients against total W. Va. patients; because out-of-state patients not counted in total, should not be counted in Medicaid portion.
	2.	Delete §6.5 because enforcement of "take one take all" against out-of-state providers is impractical.	No recommended action. Should be considered by State agency heads and advisory committee.
	3.	Amend §69-2-8 to state that burden of proof of violation of Act is on Secretary, must prove by "clear and convincing" evidence.	Add to end of §8.3 that the State shall have burden of proving violation. Amend §8.6 to provide that Secretary may impose penalty if finds violation by a "preponderance of the evidence."

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #1

FILED
1989 SEP -1 PM 3:52
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF PUBLIC HEARING ON A PROPOSED RULE

AGENCY: Department of Health and Human Resources TITLE NUMBER: 69

RULE TYPE: Legislative ; CITE AUTHORITY W. Va. Code §16-29D-7

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 2

TITLE OF RULE BEING PROPOSED: Implementation of Omnibus Health Care Act

DATE OF PUBLIC HEARING: October 16, 1989 TIME: 9:00 a.m.

LOCATION OF PUBLIC HEARING: Room 607, Building 6
Capitol Complex
Charleston, WV 25305

COMMENTS LIMITED TO: ORAL___, WRITTEN___, BOTH X

COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS: Department of Health and Human Resources
Building 6
Capitol Complex
Charleston, WV 25305

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

Taunjá Willis Miller, Secretary
Department of Health and Human Resources

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Building 6, Capitol Complex
Charleston, WV 25305

Gaston Caperton
Governor

September 1, 1989

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, West Virginia 25305

Re: W.Va.C.S.R., Title 69, Series 2; Emergency Filing of Legislative Rule; Statement of Facts and Circumstances Constituting the Emergency; Written Approval.

Dear Secretary Hechler:

This letter is written to indicate my approval of the filing of this emergency legislative rule and of the filing of the proposed permanent legislative rule. In addition, this letter indicates the basis for the filing of this legislative rule on an emergency basis.

During the past legislative session, the Legislature adopted the Omnibus Health Care Act which has been codified at West Virginia Code §16- 29D-1 et seq. Section 7 of that Act provides that the "secretary of the department of health and human resources shall promulgate rules to carry out the provisions of this article." Additional rule making authority is granted to the secretary under West Virginia Code §5F-2-2(a)(11). Moreover, West Virginia Code §5F-2-2(a)(12) requires that the secretary grant his or her written approval before any rule can have any force or effect.

The Omnibus Health Care Act authorizes divisions and departments of state government to cooperate with each other "in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of such departments and divisions and to ensure the containment of costs in the payment for such services." West Virginia Code §16-29D-3(a). While some of the divisions or departments affected by this Act are within the Department of Health and Human Resources (e.g., Division of Health, Division of Human Services, Division of Workers' Compensation), others are located within other departments (e.g., Public Employees Insurance Agency and Division of Rehabilitation Services). However, the Secretary of the Department of Health and Human Resources is authorized to administer the cooperative actions of all of these agencies which are taken pursuant to the Omnibus Health Care Act.

Accordingly, in order to effectuate the purposes of the Act, the Department is today filing on an emergency basis a legislative rule titled "Implementation of Omnibus Health Care Act." We have designated this rule as Series 2 of Title 69.

We are also filing this rule as a proposed permanent legislative rule and have scheduled the required public hearing on the date indicated in the attached documentation.

The justification for filing this rule on an emergency basis rests upon two separate bases. First, West Virginia Code §16-29D-7 indicates that emergency rules may be used. Second, as an independent basis for filing this rule on an emergency basis, West Virginia Code §29A-3-13(a) provides that an agency may propose an emergency rule and subsection 13(g) provides that "an emergency exists when the promulgation of a rule is necessary for the immediate preservation of the public peace, health, safety or welfare or is necessary to comply with a time limitation established by this code or by a federal statute or regulation or to prevent, substantial harm to the public interest." Subsection 13(a) requires that the circumstances constituting the emergency be stated with particularity.

The Legislature made the Omnibus Health Care Act effective from passage. However, the various provisions of the Act do not become operational until the various departments and divisions of state government adopt a plan or plans of cooperation. Concurrently with the filing of this emergency rule, a plan of cooperation is also being adopted by the Department and affected divisions. In addition, another emergency rule is being filed concerning the adoption of a rate methodology for the Public Employees Insurance Agency. Upon the adoption of a plan, several conditions of participation contained in the Act become operative. One condition affects the ability of health care providers to bill state program beneficiaries for the balance of charges claimed by the provider over and beyond what the state program pays. Another condition requires that a health care provider which treats one program's beneficiaries cannot discriminate against the beneficiaries of another state health program and refuse to take such beneficiaries as patients simply because they are beneficiaries of that program. The Act allows providers to indicate their refusal to participate in all of the state programs. Also, the Act provides for penalties and a procedure for the Secretary to use for health care providers who violate the Act and the rules.

This emergency rule implements all of these provisions without which the Act cannot be administered. The Legislature found that a significant and ever-increasing portion of the State's resources are being expended for health care services and yet the State has been unable to timely pay for such health care services. It found that the Public Employees Insurance Agency and the State medicaid program face serious financial difficulties in terms of decreasing amounts of available federal and State dollars to fund the programs and for paying debts presently owed. The Legislature found that "it is in the best interest of the state and the citizens thereof that the various state departments and divisions involved in such provision of health care and the payment thereof cooperate in the effecting of cost savings." West Virginia Code §16-29D-1(a)(5). It also found that the "health and well being of all state citizens, and particularly those whose health care is provided or paid for by the [state programs] are of primary concern to the state." West Virginia Code §29D-1(a)(6).

The failure to implement the Act on an emergency basis will result in the defeat of the Legislative purposes espoused in the Act and would be detrimental to the health and well being of the state program beneficiaries. Without the provisions of this rule, state health care providers would be without guidance in deciding whether or not to continue participation in the state programs, would not know whether they were in compliance with the requirement not to discriminate against classes of state program beneficiaries, and would not know when their actions would bind them to the provisions of the Act despite their intentions to withdraw from participation. In addition, patients of withdrawing providers would not receive appropriate notices of the need to seek other health care providers and many patients may be left without access to the care that they need. In short, this rule is needed so that there can be an orderly transition to the enforcement of the Omnibus Health Care Act, so as not to jeopardize the health and well-being of patients who receive their health care through the affected state programs, and so as to give affected health care providers appropriate notice of the effects of the Act upon them and the procedures open to them under the Act.

If your office desire further information on the need for the emergency promulgation of this rule, please do not hesitate to contact me at your convenience.

Very truly yours,

Taunja Willis Miller
Secretary

TWM/jah

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Implementation of Omnibus Health Care Act

Type of Rule: X Legislative _____ Interpretive _____ Procedural

Agency Department of Health and Human Resources Address Building 6
Capitol Complex
Charleston, WV 25305

1. Effect of Proposed Rule	ANNUAL Increase	ANNUAL Decrease	FISCAL YEAR Current	FISCAL YEAR Next	FISCAL YEAR Thereafter
Estimated Total Cost	$	$	$ 0	$ 0	$ 0
Personal Services					
Current Expense					
Repairs and Alterations					
Equipment					
Other					

2. Explanation of above estimates.

Monitoring of this rule will be accomplished by the existing personnel of the various state agencies conducting state beneficiary health care programs.

3. Objectives of these rules: The objective of this rule is to set forth the conditions of participation by health care providers in state beneficiary health care programs.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

This rule per se will have no economic impact on State government. The intent of the law to which this rule is related is to control the rising cost of State-supported health care programs.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of citizens.

There may be minimal costs to providers associated with record-keeping they may wish to perform to document their compliance with this rule.

C. Economic Impact on Citizens/Public at Large.

None

Date September 1, 1989

Signature of Agency Head or Authorized Representative

Taunja Willis Miller, Secretary
Department of Health and Human Resources

EMERGENCY

LEGISLATIVE RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

TITLE 69

SERIES 2

TITLE: Implementation of Omnibus Health Care Act

§69-2-1. General

1.1 Scope - This emergency legislative rule implements the provisions of the Omnibus Health Care Act, West Virginia Code, §16-29D-1 et seq., 1989. Under the Act, the Secretary of the Department of Health and Human Resources is charged with the responsibility of promulgating rules to carry out the provisions of the Act. The agencies subordinate to the Secretary under the provisions of the Act and to whom this rule is applicable are the Division of Health, the Division of Human Services, the Division of Employment Security, and the Division of Workers' Compensation. In addition, section 3 of the Act specifies that certain entities not within the Department of Health and Human Resources are also subject to the provisions of the Act and of this rule. Those other entities are the Public Employees Insurance Agency within the Department of Administration, the Division of Rehabilitation Services under the State Board of Education sitting as the State Board of Rehabilitation, and the Board of Trustees, which has responsibility for the state's medical schools, within the Department of Education and the Arts. All of these governmental entities either are involved in provision of health care services to beneficiaries of their programs or pay for health care services delivered to those beneficiaries, or both, as well as often providing many other services to the beneficiaries of

those governmental entities' programs.

1.2 Authority - West Virginia Code, §16-29D-7.

1.3 Related Rules - This emergency legislative rule is distinct from, but is to be read in conjunction with, other rules to be promulgated under the authority of West Virginia Code, §16-29D-7. One such rule will relate to procedures for administrative hearings; others will relate to payment for medical services by the departments and divisions subject to the Act.

1.4 Filing Date - September 1, 1989.

1.5 Effective Date - September 1, 1989.

§69-2-2. Definitions

2.1 As used in this emergency legislative rule, the following terms, words, and phrases have the meanings stated below unless in any instance where such term, word, or phrase is employed the context clearly indicates that another meaning is intended.

2.2 The term "Act" means the Omnibus Health Care Act which is codified at article 29D, chapter 16 of the Code of West Virginia of 1931, as amended.

2.3 The terms "Code of West Virginia" and "West Virginia Code" mean the West Virginia Code of 1931, as amended.

2.4 The term "coordination of benefits" means a provision which establishes an order in which two or more insurance contracts, plans or programs covering the same beneficiary pay their claims, with the effect that there is no duplication of benefits.

2.5 The terms "health care," "health care services," or "health care treatments" mean clinically related preventive, diagnostic, treatment, or rehabilitative services whether provided in the home, office, hospital, clinic or any other suitable place either inside or outside the state of West Virginia provided or prescribed by any health care provider or providers. Such services include, among others, medical supplies, appliances, laboratory, preventive, diagnostic, therapeutic and rehabilitative services, hospital care, nursing home and convalescent care, medical physicians, osteopathic physicians, chiropractors, and such other surgical including inpatient oral surgery, nursing, and podiatric services and supplies as may be prescribed by such health care providers but not other dental services.

2.6 The term "health care provider" means a person, partnership, corporation, facility or institution licensed, certified or authorized by law to provide professional health care services in or outside this state to an individual during this individual's medical care, treatment or confinement. For the sole purpose of this rule and the implementation of the Act, the term does not include pharmacists and pharmacies. At the option of a medical corporation, evidenced by the filing of a statement with the director of the Public Employees Insurance Agency and the assignment of separate provider numbers by the state departments and divisions paying for health care services under the provisions of the Act, each individual providing professional health care services within such corporation shall be considered as a separate health care provider.

2.7 The term "life-threatening medical or surgical emergency" shall include an emergency posing an imminent threat of significant, permanent and clearly recognizable bodily impairment such as blindness or loss of limb.

2.8 The term "this rule" means the present emergency legislative rule

which has been designated as Title 69, Series 2.

2.9 The term "the Secretary" means the Secretary of the Department of Health and Human Resources.

§69-2-3. Purpose

3.1 The purpose of this rule is to implement the Act. In adopting the Act, the Legislature stated that it intended "to provide a framework within which the departments and divisions of state government can cooperate to effect cost savings for the provision of health care services and the payment thereof. It is the purpose of the Legislature to encourage the long-term, well-planned development of fair, equitable and cost-effective systems for all health care providers paid or reimbursed by the public employees insurance agency, the state medicaid program, the workers' compensation fund or the division of rehabilitation services." West Virginia Code, §16-29D-1(b). This same purpose is applicable to the Division of Health.

3.2 In order to achieve this purpose, the Legislature directed that the state must ensure the delivery of high quality health care services and effect cost savings in the provision of health care services. The Legislature concluded that it is in the best interests of the state and its citizens for the various state departments and divisions, including the state's medical schools, which are involved in the provision of health care services and the payment thereof, to cooperate in the generation of cost savings and in ensuring the quality of the health care services delivered to the beneficiaries of all the state-supported programs.

§69-2-4. Non-Interference with the Medicaid Program

It is expressly recognized that no other entity may interfere with the

discretion and judgment given to the single state agency which administers the state's medicaid program. Thus, it is the intention of this rule that nothing contained herein shall be interpreted, construed, or applied to interfere with the powers and actions of the single state agency which, in keeping with applicable federal law, shall administer the state's medicaid program as it perceives to be in the best interest of that program and its beneficiaries.

§69-2-5. Condition of Participation - Other Program Patients

5.1 In order to assure and to increase access to quality health care services for all state program beneficiaries, and in particular the state's medicaid beneficiaries, the Act requires that any health care provider who agrees to deliver health care services to any beneficiary of a health care program of any one or more of the departments or divisions of the state, the charges for which shall be paid or reimbursed by such department or division, also not refuse to take the beneficiaries of another state program because they are beneficiaries of that other program and would have their health care services paid for under that other program. However, the health care provider retains his or her or its rights to refuse to accept any patients for reasons not related to their status as beneficiaries of such other program. Examples of such unrelated reasons are that the health care provider is not taking any new patients, that the health care provider accepts patients only upon referral and the beneficiary has not been referred, that the health care provider does not practice in the field of health care service specifically needed by the beneficiary, that the beneficiary does not require the health care services requested, that the beneficiary is an uncooperative patient which fact is known to the health care provider through the provider's own personal knowledge and experience, and similar non-discriminatory reasons.

5.2 With the exceptions noted below in subsection 5.4, any health care provider who agrees to provide covered health care services to any beneficiary of a state program shall also be deemed to agree to take as patients for covered services the beneficiaries of all other state programs. Refusal to take a particular beneficiary or class of beneficiaries because, in whole or in part, the individual or class of individuals are participants in a particular state program shall cause the health care provider to be in violation of the Act and this rule.

5.3 A health care provider will be presumptively in compliance with the provisions of subsection 5.2 of this rule, if

5.3.1 The health care provider actually delivers covered health care services to all such beneficiaries who request such services or refuses only for reasons not related to such persons' status as beneficiaries as provided in Section 5.1; or

5.3.2. With respect to beneficiaries of the state's medicaid program, the health care provider actually delivers health care services to a sufficient number of patients who are beneficiaries of the state's medicaid program to equate to at least fifteen (15) percent of the health care provider's total active patient population. An active patient is one to whom the health care provider has delivered health care services within the two years preceding the date on which the determination is being made. For those health care providers who practice in both obstetrics and gynecology, such a provider will be presumptively in compliance with respect to beneficiaries of the state's medicaid program if the provider actually delivers covered health care services to all such beneficiaries who request obstetric services, or to at least a sufficient number of such beneficiaries to equate to at least fifteen (15) percent of the provider's total active obstetric patient population and, if

the provider actually delivers covered health care services to all such beneficiaries who request gynecological services, or to at least a sufficient number of such beneficiaries to equate to at least fifteen (15) percent of the provider's total active gynecological patients.

5.3.2.1 In making a determination of the sufficient number of patients who are beneficiaries of the state's medicaid program to equate to at least fifteen (15) percent, nothing in this rule should be construed as requiring the provider to cease delivering health care services to patients who are beneficiaries of other states' medicaid programs. Provided, however, that in determining presumptive compliance under subsection 5.3.2 of these rules, a sufficient number of patients who are beneficiaries of the state's medicaid program will be equated to at least fifteen (15) percent of the provider's active patients who are state residents. Provided, however, that the provider does not refuse to take beneficiaries of this state's medicaid program as his or her practice admits appropriate new patients. Provided further that the provider does not discriminate in accepting patients in favor of beneficiaries of another state's medicaid program and against beneficiaries of this state's medicaid program because of differing rates of reimbursement.

5.3.3 With respect to beneficiaries of the state's medicaid program, the health care provider expends a substantial amount of his, her or its actual practice time, equal to approximately fifteen (15) percent, providing services to patients who are beneficiaries of the state's medicaid program, or other programs recognized by the Secretary as serving indigent citizens of the state, either in the provider's own practice or facility, or in practice settings or sites which are operated or organized by the state or federal government or not-for-profit corporations, organizations or agencies, or some combination of both. Full-time and clinical faculty of teaching programs

recognized by the Secretary as serving indigent citizens of the state may count toward the fifteen (15) percent practice time hours spent either directly providing patient care in connection with such program or time spent assisting, consulting with, supervising or training students in the actual provision of such patient care.

5.4 The implied agreement set forth in subsection 5.2 shall not arise in the following circumstances:

5.4.1 When the health care provider delivers health care services to a state program beneficiary which are immediately needed to resolve an imminent life-threatening medical or surgical emergency; however, once the disease or injury which caused the emergency is stabilized, then further treatment of that beneficiary by the health care provider will give rise to the implied agreement. Provided, however that the health care provider must be willing to deliver health care services to any state program beneficiary which are immediately needed to resolve an imminent life threatening medical or surgical emergency, until the disease or injury which caused the emergency is stabilized. For the purpose of this subsection, stabilize means resolved or no longer requiring treatment for the specific occurrence; or

5.4.2 When a physician who is on the staff of a hospital or other health care facility and who as part of his or her duties as an on-call staff physician must deliver health care services to persons who present themselves at the facility, then if any such person is a beneficiary of a state program the implied agreement set forth in subsection 5.2 will not arise as a result of the health care provider's delivering health care services and all necessary follow-up services to that beneficiary. Provided, that the health care provider must deliver health care services as such on-call staff physician and all

necessary follow-up services to the beneficiaries of any state program presenting themselves at the facility. However, if the health care provider delivers health care services to that beneficiary for an unrelated condition as part of the health care provider's private practice, then the implied agreement will arise. An example of this sub-subsection is a physician who is on the staff of a hospital which has medical staff bylaws requiring all physicians to take turns in the hospital's emergency room and to treat all persons who present themselves for health care services at that emergency room. The treatment of a state program beneficiary who comes to the emergency room by a physician and the provision of all necessary follow-up services will not obligate that physician to deliver health care services to other state program beneficiaries. But, if the physician elects to treat that beneficiary for unrelated conditions in the physician's private office, then the implied agreement to treat other state program beneficiaries will arise at the time the unrelated treatment is provided.

§69-2-6. Withdrawal by Health Care Providers from Participation

6.1 A health care provider may withdraw from providing health care services to beneficiaries of the health care programs of the departments and divisions of the state pursuant to a plan or plans developed in accordance with the Act. In order to effect the withdrawal, the health care provider shall provide a written notice to the director of the Public Employees Insurance Agency which shall state that the provider intends to withdraw from participation in such plan or plans. The effective date of withdrawal for the purposes of this rule shall be the date of receipt of the written notice by the director of the Public Employees Insurance Agency. The written notice shall be sent to the director of the Public Employees Insurance Agency by certified mail,

return receipt requested. The notice shall identify the health care provider by name, by FEIN (tax) number, and by address and telephone number.

6.2 As a general rule, the health care provider shall have forty-five (45) days from the effective date of the provider's withdrawal within which to cease continued treatment of the provider's patients who are state program beneficiaries. Not later than ten (10) days after the effective date of withdrawal, the withdrawing provider shall give his, her or its state program beneficiary patients written notice of such provider's withdrawal, to enable these patients to arrange for care by other providers. Failure by the provider to deliver the notice to a patient within the ten (10) day period shall render the provider's charge for any health care services delivered beyond the forty-five (45) day period null and void and they shall not be recoverable from either the beneficiary or the state division or department. Exceptions to this general rule are stated below. During the forty-five (45) day period, the health care provider may continue to provide health care services to state program beneficiaries who were patients of the provider prior to the effective date of the provider's withdrawal. With the exceptions noted in subsection 6.4, within the aforesaid forty-five (45) day period the provider may not undertake the initial delivery of health care services to state program beneficiaries who were not patients of the provider prior to the date of receipt of the provider's withdrawal notice by the director of the Public Employees Insurance Agency or who had not been seen by the provider for the actual delivery of health care services for a period of two (2) years prior to such date of receipt. The delivery of health care services during the forty-five (45) day period to such pre-established patients shall not obligate the health care provider to deliver health care services to other state program beneficiaries.

6.3 As exceptions to the general rule stated in subsection 6.2 of this

rule, the health care provider may elect to continue to treat individual state program beneficiaries who he, she or it is treating as of the effective date of this rule in the following specific categories without obligating the provider to undertake the delivery of health care services to state program beneficiaries. However, nothing in this subsection shall permit the health care provider to continue to provide health care services beyond the forty-five (45) day period described in subsections 6.1 and 6.2 to previously established state program beneficiaries who do not come within the following specific categories of patients or permit the provider to accept new state program beneficiaries as patients after the effective date of his, her or its withdrawal. The purpose of these exceptions is to ensure the continued access to quality health care services in these special situations during the transitional period for implementation of the Act.

6.3.1 An obstetrical patient for whom the health care provider has been providing prenatal care. In this event, the health care provider may continue to deliver health care services to the patient until the outcome of the pregnancy and after the completion of customary medical follow-up health care. The health care provider shall file a statement with the director of the Public Employees Insurance Agency identifying the provider by name, FEIN (tax) number, address and telephone number, and identifying any such patients by name, address, and social security number.

6.3.2 A patient whose condition places him within a risk of suffering serious and permanent harm if such patient has been unable, after good faith efforts, to secure a health care provider of equivalent training. In this event, the health care provider may continue to deliver health care services to the patient until the risk of suffering serious and permanent harm has abated or the patient can obtain care from a health care provider of equivalent training.

The health care provider shall file a statement with the director of the Public Employees Insurance Agency which shall identify the provider by name, FEIN (tax) number, address and telephone number and identify the patient by name, address, social security number and, in the case of a beneficiary of the Division of Workers' Compensation, claim number. The statement shall give the history, diagnosis, and prognosis for the patient and such other information as the health care provider believes will best describe the patient's condition and shall include documented medical records.

6.3.3 A patient who, despite good faith efforts, has been unable to secure a replacement health care provider of equivalent training and who receives permission from the director of the Public Employees Insurance Agency to continue to receive health care services from the patient's withdrawing health care provider after the expiration of the forty-five (45) day period. Either the patient or the health care provider may petition the director of the Public Employees Insurance Agency for such permission. The petition shall be accompanied by a statement from the provider identifying any conditions which may require ongoing medical attention and indicating the provider's willingness to continue to provide health care services to that beneficiary. Further, the petition shall state in detail the efforts made by the patient or others on the patient's behalf to secure an equivalently trained health care provider and the reasons for the failure of those efforts. The director of the Public Employees Insurance Agency may exercise his or her discretion to grant a waiver to the patient upon being satisfied that there have been good faith efforts made to locate an equivalently trained health care provider, that those efforts have failed for reasons beyond the control of the patient or others working on behalf of the patient or of the health care provider, and that continued treatment by the health care provider is reasonably necessary

for the health and well being of the patient.

6.3.4 In any case where a health care provider has been delivering health care services to a patient whose condition is expected to be terminal, the health care provider may continue such patient's treatment upon obtaining permission from the director of the Public Employees Insurance Agency. In order for the patient or the health care provider to avail himself, herself, or itself of this exception, either the patient, the patient's family member or the provider shall file a petition with the director of the Public Employees Insurance Agency requesting permission to continue the treatment. The petition shall be accompanied by a statement from the provider, setting forth the provider's reasons for believing that the patient's condition is terminal. Upon being satisfied that the facts stated in the petition are correct and that the opinions stated therein are reasonable and based upon the asserted facts, the director of the Public Employees Insurance Agency may permit the health care provider to continue the delivery of health care services to that particular patient.

6.3.5 In any other case, either the patient or the health care provider may petition the director of the Public Employees Insurance Agency for permission for the withdrawing health care provider to continue the delivery of health care service to a particular patient. The petition shall state in detail the facts and arguments relied upon by the petitioner for the relief requested. The director of the Public Employees Insurance Agency shall have the discretionary power to grant or refuse the relief requested. In exercising his or her discretion, the director shall consider the access to quality health care otherwise available to the patient, the nature of the injury, condition, or disease from which the patient suffers, the threat posed to the patient from that injury, condition, or disease in the absence of access to quality health

care, and such other factors as may appear to the director to warrant the granting or denying of the relief requested. The director shall respond to all petitions filed pursuant to subsection 6.3 of this rule in a timely manner. No provider or beneficiary shall be penalized during the period in which he or she is awaiting the director's response, provided the petition was filed in good faith and on a timely basis.

6.3.6 In any case where the director of the Public Employees Insurance Agency denies the relief requested in a petition filed under this subsection 6.3 or rejects the continued treatment by the health care provider of the patient under sub-subsections 6.3.1 or 6.3.2 for beyond the forty-five (45) day period described in subsections 6.1 and 6.2 either the patient or the health care provider may appeal the director's determination by filing with the Secretary a request for an administrative hearing. At the hearing, the burden of proof on all pertinent issues shall be upon the person requesting the hearing. The hearing shall be conducted in accordance with the Administrative Procedures Act, West Virginia Code, §29A-5-1 et seq., and applicable procedural rules promulgated by the Secretary.

6.4 Nothing in this section shall prohibit a beneficiary of a state program from seeking health care services from any provider of his or her own choosing. However, if that provider has elected to withdraw, in accordance with Section 6 of this rule, from providing health care services to beneficiaries of the health care programs of departments or divisions of the state pursuant of the Act and this rule, then the cost of health care services received from such withdrawn provider will not be considered a covered service within the meaning of Section 4(a) of the Act and will not be paid for by any state department, division or agency in accordance with the Act, whether as a primary or secondary payor of health care services for said beneficiary. This exclusion

applies only to the services actually rendered by the withdrawn provider. If the withdrawn provider treats the patient in a hospital or other facility, the hospital charges and other services rendered and charged for separately by other providers (e.g., anesthesiology, laboratory work) will not be excluded merely because they were ordered by a withdrawn provider, unless the provider actually providing and charging for the service is also a withdrawn provider.

6.4.1 A provider delivering health care services and a beneficiary seeking health care services under this subsection 6.4 must both complete and sign a waiver, provided by the director of the Public Employees Insurance Agency, releasing all state programs or plans of any responsibility for payment of the services delivered through or by this private physician-patient agreement.

6.5 Out-of-state health care providers who refuse to provide covered health care services to any class of beneficiaries of a state health care program may be presumed to have withdrawn from providing health care services to beneficiaries of all state programs in the state plan or plans developed in accordance with the Act. In such instance, the Secretary or his or her designee may formally communicate with such out-of-state provider to determine whether the provider intends to comply with the Act, this rule, and any applicable plan, order or directive. If the provider refuses to so comply, or refuses to state clearly its position, then the Secretary or his or her designee may deem the provider to be a withdrawn provider, and any further services provided by such provider will be considered under Section 6 of this rule.

§69-2-7. Testimony By Providers

Nothing in this rule or in the Act shall be deemed to prohibit a health care provider who has elected not to participate in the provision of health care services to state program beneficiaries (but who may have provided

covered services to such beneficiaries prior to such election) from testifying on behalf of or against a state program beneficiary in any administrative or judicial proceeding. Divisions or agencies which otherwise have the responsibility of reimbursing such health care providers for the time expended by the provider in so testifying shall continue to do so notwithstanding any other provision of this rule or the Act. Further, such testimony shall not obligate any health care provider who has previously elected not to participate in the delivery of health care services to state program beneficiaries to begin the delivery of such services.

§69-2-8. Violations and Show Cause Proceedings; Penalties

8.1 In the event that any health care provider or other legal entity violates any provision of the Act, of this rule, of any other rule duly promulgated by the Secretary under the provisions of the Act, or any plan, order, or directive issued under the provisions of the Act or any such rule, then the Secretary may assess a civil penalty for each such violation and may order that the health care provider be removed from any list of providers for whose services a department or division may pay in the future.

8.2 Upon determining that there is probable cause to believe that a health care provider or other legal entity may be knowingly engaging in such a violation, the Secretary shall provide such health care provider or other legal entity with written notice which shall state the nature of the alleged violation and the time and place at which such health care provider or other legal entity shall appear to show cause why a civil penalty or removal from any list, or both, should not be imposed.

8.2.1 For the purposes of violation of Section 5 of this rule, a finding of probable cause shall be based upon a pattern of incidents in which

beneficiaries of one or more particular programs have been denied health care services by a provider or an agent acting on behalf of the provider. Isolated first person reports or report by others that a person was denied health care services will not be a basis for a finding of probable cause, unless other corroborative evidence is received.

8.3 At the hearing so noticed, the Secretary shall arrange to have the evidence in support of the allegations presented and shall afford the health care provider or other legal entity an opportunity to cross-examine the state's witnesses and shall afford the health care provider or other legal entity an opportunity to present testimony and enter evidence in support of its position.

8.5 The hearing shall be conducted in accordance with the administrative hearings provisions of West Virginia Code, §29A-5-1 et seq., and applicable procedural rules promulgated by the Secretary.

8.6 If, after reviewing the record of such hearing, the Secretary determines that such health care provider is in violation of the Act, of this rule, or any other rule promulgated under the Act, or any plan, order, or directive issued under the Act or such rule, the Secretary may assess a civil penalty of not less than one thousand dollars nor more than twenty-five thousand dollars, and may remove a health care provider from any list. In exercising his or her discretion in fixing the amount of the penalty as well as whether to remove a health care provider from a list, the Secretary shall be guided by the degree of willfulness shown in the violation, the nature and type of the violation, the monetary amount involved and whether the health care provider or other legal entity had personally gained by the violation, the degree of harm, if any, suffered by a beneficiary of any state supported program due to the violation, and such other factors as may appear in a particular case.

8.7 Any health care provider or other legal entity proceeded against under

this Section 8 shall receive notice in writing by certified mail of the decision, which decision shall contain a statement of the penalty imposed, if any, whether the health care provider is to be removed from any applicable list and the Secretary's findings of fact and conclusions of law in support of the exercise of the Secretary's discretion in the manner stated. The penalty and the removal may be imposed immediately by the Secretary without regard to whether or not an appeal is filed; however, the Secretary, in his or her discretion, may grant a stay of enforcement or collection of the penalty or removal pending the resolution of an appeal.

8.8 As provided for by West Virginia Code, §16-29D-8, the health care provider or other legal entity may appeal the Secretary's decision. Any such appeal shall be taken and be handled in accordance with West Virginia Code, §29A-5-4. The circuit court's review shall include a review of the amount of the penalty and any removal of a health care provider. The circuit court may enter a stay against the collection or enforcement of any penalty or removal order after a hearing on the request for stay; however, such hearing may not be conducted on an ex parte basis.

8.9 If the health care provider or other legal entity penalized or ordered removed either loses on appeal or has not appealed such penalties or removal and fails to pay the amount of the penalty to the Secretary within thirty days or if the health care provider continues to act in a manner contrary to his or her or its removal, the Attorney General may institute a civil action in the circuit court of Kanawha County to recover the amount of the penalty or to seek an injunction. Such civil action shall be handled in an expedited manner by the circuit court and shall be assigned for hearing at the earliest possible date.

8.10 The remedies set forth in this section are intended only for

violations of the Act and shall not affect any other contractual relationship between any department or division and a health care provider or other legal entity.

8.11 Any health care provider removed from a list pursuant to this Section 8 may petition the Secretary for reinstatement to such list after one-hundred and eighty (180) days from his removal. Any appeal by the provider of the Secretary's decision shall be taken and handled in accordance with West Virginia Code, §29A-5-4.

§69-2-9. Declaratory Rulings and Informal Opinions

If in any particular instance a health care provider wishes to request that the Secretary make a determination of the applicability of any section of this rule, or of any exception contained therein, to a given state of facts, the health care provider may request either an informal opinion or a declaratory ruling from the Secretary in accordance with the provisions of West Virginia Code, §29A-4-1.

§69-2-10. Severability

If any provision of this rule or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not affect the provisions or the applications of this rule which can be given effect without the invalid provisions or application, and to this end the provisions of this rule are declared to be severable.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Building 6, Capitol Complex
Charleston, WV 25305

Gaston Caperton
Governor

September 1, 1989

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, West Virginia 25305

Re: Omnibus Health Care Act - Cooperative Plan

Dear Secretary Hechler:

During the past legislative session, the Legislature adopted the Omnibus Health Care Act which had been codified at West Virginia Code §16-29-D-1 et seq. Subsection 3(c) of the Act requires the departments and divisions subject to the Act to "develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including the Public Employees Insurance Agency and the Workers' Compensation Fund, the Division of Rehabilitation Services and, to the extent permissible, the State Medicaid Program. The Legislature made the Act effective from passage. However, various provisions of the Act do not become operational until the departments and divisions of State government adopt a plan or plans of cooperation. The Department of Health and Human Resources, the Divisions of Health, Human Services and Workers' Compensation within the Department, the Public Employees Insurance Agency and the Division of Rehabilitation Services have adopted on this date the attached plan of cooperation. Please file the plan as an official record of the Department of Health and Human Resources, the Public Employees Insurance Agency and the Division of Rehabilitation Services.

If your office desires further information regarding the Cooperative Plan, please do not hesitate to contact me at your convenience.

Very truly yours,

Taunja Willis Miller
Secretary

Attachment