WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #1

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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: Procedural ; CITE AUTHORITY §5F-2-2 and §29A-5-1 et.seq.

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: 1

TITLE OF RULE BEING PROPOSED: Rules for Hearings Under the Administrative Procedures Act

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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

Taunja 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

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OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

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 1; Approval of Filing of Procedural Rule for Public Hearing

Dear Secretary Hechler:

This letter is written to indicate my approval of the proposed procedural rule, "Rules for Hearings Under the Administrative Procedures Act" for public hearing.

Very truly yours,

Taunja Willis Miller
Secretary

TWM/jah

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Rules for Hearings Under the Administrative Procedures Act

Type of Rule: _____ Legislative _____ Interpretive X 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.

The costs of conducting any hearings under this procedural rule will not require funding over the current budget.

3. Objectives of these rules:

This rule sets forth procedures for the conduct of administrative hearings by the Secretary of the Department of Health and Human Resources.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None

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

Parties participating in an administrative hearing may incur costs for legal representation, preparation of evidence, travel and other activities related to the hearing.

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

WEST VIRGINIA PROCEDURAL RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

TITLE 69

SERIES 3

TITLE: Rules For Hearings Under The Administrative Procedures Act.

TABLE OF CONTENTS

SECTION		PAGE
§69-1-1.	General	1
§69-1-2.	Definitions	2
§69-1-3.	Administrative Hearings; Notice; and Place	2
§69-1-4.	Parties and Conduct of Hearings	4
§69-1-5.	Correction of the Record	6
§69-1-6.	Subpoenas	7
§69-1-7.	Discovery	9

TABLE OF CONTENTS - CONTINUED

SECTION		PAGE
§69-1-8.	Hearing Officers	9
§69-1-9.	Concluding The Hearing	10
§69-1-10.	Severability	11

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SECRETARY OF STATE

WEST VIRGINIA PROCEDURAL RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

TITLE 69

SERIES 1

TITLE: Rules For Hearings Under The Administrative Procedures Act.

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§69-1-1. General

1.1 Scope - This procedural rule is intended to set forth the procedures for administrative hearings which are conducted by the Secretary of the Department of Health and Human Services pursuant to the West Virginia Administrative Procedures Act, West Virginia Code, §29A-5-1 et seq.

1.2 Authority - West Virginia Code, §5F-2-2 and §29A-5-1 et. seq.

1.3 Filing Date - , 1989.

1.4 Effective Date - . 1989.

§69-1-2. Definitions

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

2.2 The term "Act" means the specific statute under which a hearing arises and which statute is among the various statutes for which the Secretary of the Department of Health and Human Resources has administrative responsibility under the provisions of West Virginia Code, §5F-2-1(d).

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 "this rule" means the present procedural rule which is designated in the caption hereof as Title 69, Series 3.

2.5 The term "Secretary" means the Secretary of the Department of Health and Human Resources as provided for by West Virginia Code, §5F-1-1 (1989).

§69-1-3. Administrative Hearings; Notice; and Place.

3.1 All administrative hearings conducted pursuant to this rule will be held in accordance with the provisions of West Virginia Code, §29A-5-1 et seq., and with the provisions of this rule. In any particular case, any special conditions which are set forth in the Act or in other rules promulgated by the Secretary and which are applicable to that case will be adhered to during administrative hearings in lieu of any contrary provision in this rule.

3.2 Unless waived by all the parties to the hearing and by the Secretary, all hearings shall be preceded by at least ten (10) days written notice. The notice shall be given either by personal delivery thereof to the person or to the entity to be notified or by depositing such notice in the certified United States mail, postage prepaid, return receipt requested, in an envelope addressed to such person or other entity at the last known address of such person or other entity. Proof of the giving of notice in either such manner may be made by the affidavit of any officer or assistant or employee of the Secretary, or by affidavit of any person over eighteen years of age, naming the person or other entity to which or to whom such notice was given and specifying the time, place and manner of the giving thereof. If certified mail is used, then a copy of the return receipt shall be attached to the proof of notice.

3.3 Notice of the hearing and service of any document or order shall be upon the parties of record except that any party who is represented by an attorney shall be deemed to have designated that attorney as the proper recipient of all such notices, documents, or orders and service upon that attorney will be the equivalent for all purposes as service upon the party. Notice shall be complete if the written notice is personally tendered to the intended recipient and is either accepted or refused by that recipient. Similarly, notice shall be complete if the written notice is sent by certified mail, return receipt requested, to the recipient and the return receipt shows that it was either accepted by a person at the last known address or was refused by a person at the last known address.

3.4 In any instance where any form of notice, including one arising under subsection 3.2 of this rule or one contained in any order or document, the time period will begin to elapse with the first day following the date of the notice, order, or document. This rule is applicable whether the notice is delivered personally or served by mail.

3.5 The subsection 3.2 notice shall contain the date, time, and place of the hearing and a short and plain statement of the matters asserted. If the Secretary is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application by a party a more definitive and detailed statement shall be furnished.

3.6 The hearing shall be held in the county selected by the Secretary.

§69-1-4. Parties and Conduct of Hearings

4.1 At the hearing, an opportunity shall be afforded all parties to present evidence and argument with respect to the matters and issues involved. Any person interested in the proceeding, but not a party thereto, shall be permitted to testify as to the issues in controversy after first being placed under oath or affirmation. Any such interested person, who is not a party, shall not, however, be permitted to submit argument or to cross-examine other witnesses. Argument may be restricted to a presentation in written form. All of the testimony and evidence at the hearing shall be reported by stenographic notes and characters or by mechanical means. All rulings on the admissibility of testimony and evidence shall also be reported. The Secretary shall prepare an official record, which shall include reported testimony and exhibits in each contested case, and all agency staff memoranda and data used in consideration of the case, but it shall not be necessary to transcribe the reported testimony unless required for purposes of rehearing or judicial review. Upon request from any party to the hearing, all reported testimony and evidence at a hearing shall be transcribed, and a copy thereof furnished to the party at its expense. The Secretary shall have the responsibility for making arrangements for

the transcription of the reported testimony and evidence and such transcription shall be accomplished with all dispatch.

4.2 Evidentiary depositions may be taken and read as in civil actions in the circuit court of this state.

4.3 Except to the extent required by statute or by this rule, all hearings under this rule will be conducted in accordance with the then current versions of the "Rules of Civil Procedure for Trial Courts of Record," "Trial Court Rules for Trial Courts of Record," and "Local Rules for Kanawha County Civil Courts" as those rules would apply to a trial court sitting without a jury.

4.4 All hearings shall be conducted in an impartial manner and shall be open to members of the public. The Secretary and every Hearing Officer appointed by the Secretary shall have the power to administer oaths and affirmations, certify official acts, take depositions, rule upon offers of proof and receive relevant evidence, regulate the course of the hearing, hold conferences for the settlement or simplification of the issues by consent of the parties, dispose of procedural requests, motions, or similar matters, and take such other actions as are authorized by this rule.

4.5 During a hearing, irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The then current "Rules of Evidence" as applied in civil cases by a court sitting without a jury shall be followed. However, when necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not admissible thereunder may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their office. The Hearing Officer shall be bound by the rules of privilege recognized by law. Objections to evidentiary offers shall be noted in the record, but exceptions to rulings by the Hearing Officer shall not be made. Any party to any hearing may vouch the record as to any excluded

testimony or other evidence provided that the Hearing Officer may elect to require that the excluded testimony be submitted in written form following the hearing.

4.6 All evidence, including papers, records, agency staff memoranda and documents in the possession of the Secretary, of which he or she desires to avail himself or herself, shall be offered and made a part of the record in the case, and no other factual information or evidence shall be considered in the determination of the case. Documentary evidence may be received in the form of copies of excerpts or by incorporation by reference. In all cases, copies of orders, proceedings, or records in the office of the Secretary shall be equal to the original in evidence.

4.7 Every party as well as the Secretary and his or her staff shall have the right of cross-examination of witnesses who testify, and shall have the right to submit rebuttal evidence.

4.8 All witnesses who testify during a hearing shall first be subject to oath or affirmation and any testimony submitted by deposition shall show on the face thereof that the witness was so qualified.

4.9 The Hearing Officer may take notice of judicially cognizable facts. All parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material so noticed, and they shall be afforded an opportunity to contest the facts so noticed.

§69-1-5. Correction of the Record

Upon motion in writing served by any party or by the Secretary as notice may be served pursuant to subsection 3.2 of this rule and therein assigning error or omission in any part of any transcript of

the proceedings had and testimony taken at any such hearing, the Hearing Officer shall settle all differences arising as to whether such transcript truly discloses what occurred at the hearing or shall direct that the transcript be corrected and revised in the respects designated by the Hearing Officer, so as to make it conform to the whole truth.

§69-1-6. Subpoenas

6.1 The Secretary may issue subpoenas and compel the attendance of witnesses and the production of pertinent books, accounts, papers, records, documents, and testimony. All subpoenas and subpoenas duces tecum shall be issued in the name of the Secretary, but any party requesting their issuance must see that they are properly served. Service of subpoenas duces tecum issued at the instance of the Secretary shall be the responsibility of the Secretary. All requests by interested parties for subpoenas and subpoenas duces tecum shall be in writing and shall contain a statement acknowledging that the requesting party agrees to pay service fees and fees for the attendance and travel of witnesses.

6.2 Every subpoena or subpoena duces tecum shall be served at least five (5) days before the return date thereof, either by personal service made by any person over eighteen years of age or by registered or certified mail. But a return acknowledgment signed by the person to whom the subpoena or subpoena duces tecum is directed shall be required to prove service by registered or certified mail. If service is by mail, then the five (5) day notice period shall not begin to run until the date the subpoena or subpoena duces tecum is received by the person or entity subject thereto as shown by the date on the return receipt.

6.3 Any person who serves any such subpoena or subpoena duces tecum shall be entitled to the same fee as sheriffs who serve

witness subpoenas for the circuit courts of this state. Fees for the attendance and travel of witnesses shall be the same as for witnesses before the circuit courts of this State. All such fees shall be paid by the Secretary if the subpoena or subpoena duces tecum was issued, without the request of an interested party, at the instance of the Secretary. All such fees related to any subpoena or subpoena duces tecum issued at the instance of an interested party shall be paid by the party who asks that such subpoena or subpoena duces tecum be issued.

6.4 Upon motion made promptly and in any event before the time specified in a subpoena duces tecum for compliance therewith, the circuit court of the county in which the hearing is to be held, or the circuit court in which the subpoena duces tecum was served, or the judge of either such court in vacation, may grant any relief with respect to such subpoena duces tecum which either such court, under the West Virginia Rules of Civil Procedure for Trial Courts of Record, could grant, and for any of the same reasons, with respect to a subpoena duces tecum issued from either such court.

6.5 In case of disobedience or neglect of any subpoena or subpoena duces tecum served on any person, or the refusal of any witness to testify to any matter regarding which he or she may be lawfully interrogated, the circuit court of the county in which the hearing is being held, or the judge thereof in vacation, upon application by the Secretary, shall compel obedience by attachment proceedings for contempt of a subpoena or subpoena duces tecum issued from such circuit court or a refusal to testify therein.

6.6 The issuance of a subpoena duces tecum will be refused only in an instance when there is good reason to believe that the subpoena power is being abused. All subpoenas and subpoenas duces tecum will state on their face the name of the party who requested it.

§69-1-7. Discovery

Discovery shall be engaged in only with the consent of the Hearing Officer or, if a Hearing Officer has not yet been assigned, with the consent of the Secretary. All discovery requests will be submitted to the appropriate official at the same time as the discovery request is served upon the other party. If the official determines that the requested information is relevant and material to the issues to be heard and not unduly burdensome, the official will permit the discovery and set a reasonable time frame for the disclosure of the information. Determination of a reasonable time frame will be premised upon the nature and scope of the information requested and the date on which the hearing is scheduled. The official shall attempt to avoid continuing a previously scheduled hearing.

§69-1-8. Hearing Officers

8.1 Every Hearing Officer appointed by the Secretary to conduct a hearing under this rule shall be an attorney licensed to practice law in this State.

8.2 The Hearing Officer is authorized to receive and rule upon any procedural matter arising before, during, or after a hearing. All final rulings on substantive matters shall be made by the Secretary.

8.3 The Hearing Officer shall continue a hearing upon motion of the Secretary. Requests for continuances by a party shall not be granted as a matter of course, but only upon a showing of good cause which cause shall be strictly construed against the requests.

§69-1-9. Concluding The Hearing

9.1 At the conclusion of the hearing, the parties shall be permitted to file proposed findings of fact, conclusions of law, and such legal briefs or memoranda as they wish. The parties shall be permitted seven (7) days to file such items which filings shall be concurrent. The parties shall be permitted three (3) days to respond to the filing of any other party. No further argument shall be permitted.

9.2 Thereafter, unless the Secretary served as the Hearing Officer in the particular case, the Hearing Officer will prepare a report and recommendation which shall contain proposed findings of fact and conclusions of law as suggested by the Hearing Officer for the Secretary's approval. The parties to the hearing shall then be permitted seven (7) days in which to file objections or comments upon the report and recommendation and three (3) more days to respond to each others' objections or comments. Thereafter, the Secretary shall decide whether to accept the report and recommendation, to reject it, to modify it, or to remand the matter to the Hearing Officer for further proceedings or upon other instructions. The Secretary retains his or her right to review any and all proposed findings of facts against the record and to disagree therewith provided that the Secretary states the basis for the disagreement in his or her final order. The Secretary shall render either a final order or an interlocutory order as his or her decision may require in which the Secretary accepts in whole or in part the proposed findings of fact and conclusions of law submitted by the Hearing Officer and, to the extent that the Secretary rejects or modifies the report and recommendation of the Hearing Officer, the Secretary shall furnish his or her own findings of fact and conclusions of law. If in a particular case the Secretary personally served as the Hearing Officer, the Secretary shall issue a decision following his or her review of the proposed findings of fact, conclusions of law, and legal briefs or memoranda.

9.3 A copy of the final order or decision of the Secretary shall be served upon each party and the party's attorney of record, if any, either in person or by certified mail.

9.4 All appeals from the final order or decision of the Secretary shall be taken pursuant to West Virginia Code, §29A-5-4.

§69-1-10. 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 affect without the invalid provisions or application and to this end the provisions of this rule are declared to be severable.

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1989 SEP -1 PM 3:55
OFFICE OF [illegible]
SECRETARY OF STATE

PLAN FOR IMPLEMENTATION

OF

SENATE BILL NUMBER 576

September 1, 1989

PLAN FOR IMPLEMENTATION OF SB 576

Outline

I. Introduction

A. Statement of the Problem

B. Background of Senate Bill 576, the West Virginia Omnibus Health Care Act of 1989

II. The Plan

A. Introduction

B. Description of Participating Agencies and Departments

C. Implementation of SB 576 Development and Implementation of Coordinated Plan

Phase One: Incorporation by Reference of Current Rules, Policies and Practices of Participating Agencies

Phase Two: Development of Coordinated Agency Work for Fiscal Year 1990

--Interagency Planning Committee

--Ensuring Access to Care: Section 3(e)

-- Section 3 Implementation

--Ensuring Containment of Costs

1) Section 4 Implementation

2) Joint Utilization Review and Quality Assurance

3) Joint Review of Claims Processing and Fee Schedules

4) Joint Agency Involvement in HCCRA Proceedings

--Ensuring Quality of Care

1) Utilization Review and Quality Assurance

2) Involvement of the medical schools in development of quality assurance guarantees

--Ensuring Fairness to Providers

1) Implementation of Prompt Pay Requirements of Section 3(i)

2) Keeping the lines of communication open:

-- Informal comments

-- Formal comment on rules

-- Advisory Committee

-- Utilization Management Committee

Enforcement and Penalties

Rules to Implement the Omnibus Health Care Act

1) Implementation of Section 3(e)

2) Implementation of Section 4

3) Procedural Rules

Future Planning

ATTACHMENTS

I. INTRODUCTION

A. STATEMENT OF THE PROBLEM

The economic, social and personal aspects of our lives are affected by the availability, accessibility and quality of health care. As the costs of health care increase nationwide, many are finding that basic health services are beyond their means or otherwise unavailable[1]. Overall health care costs are skyrocketing; the Consumer Price Index shows a steady increase for all medical care of 83.9% from 1980 to 1988[2]. The federal Health Care Financing Administration also verifies a dramatic increase in spending for health care in the past decade. By 1990, health care is expected to reach 11.3% of the gross national product.

This dramatic increase in costs has affected the health care programs funded by or through the State of West Virginia. The Public Employees' Insurance Agency (PEIA) showed a 26% increase in medical expenditures from FY 1987 to FY 1989. The monthly claim cost, per employee rose 36% from 1988 to 1989.

Similarly, the West Virginia Medicaid program costs have

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[1]From 1980 to 1986 there was about a 24% increase in the number of people without health care coverage who received either no care or uncompensated care. In West Virginia, one out of six citizens was without health care coverage in 1986. Attachment A-1 contains excerpts from the study on West Virginia's uncompensated care done by the staff of the Robert Wood Johnson Foundation Uninsured Project. Attachment A-2 shows the level of uncompensated care experienced by West Virginia hospitals in 1988.

[2]See Attachment A-3 from the CPI Detailed Report, December 1988.

increased steadily (Attachment A-4). From 1984 through 1988 there was a 53% increase in program costs. Over half of the deliveries of babies are Medicaid covered, and they are often complicated by lack of prenatal care. Recent estimates reveal that over 70% of long term care services in West Virginia are funded by Medicaid; nursing home care constitutes one-third of the total Medicaid budget, yet only 4% of the total Medicaid recipients are nursing home patients.

Nationally, medical expenses constitute from one-third to one-half of workers' compensation costs. West Virginia Workers' Compensation experienced an annual average rate of increase of health care costs of 17.8% from 1982 through 1987. (Attachment A-5) Although the increase of these costs has been somewhat contained by the institution of a medical cost containment system by the Workers' Compensation Fund, nevertheless overall medical costs increased approximately 10% from 1988 to 1989.

From 1983 through 1988, the West Virginia Division of Rehabilitation Services experienced a substantial increase in the percentage of expenditures attributed to health care, as compared to other rehabilitation services. In 1983, 47% of the total case services budget was spent for health care. The percentage increased to 57% in 1988. This impacts the availability of other services which may be provided through rehabilitation programs, such as education, training, and environmental modifications.

More than one out of every four persons in West Virginia is covered by public health care programs. See Attachment A-6. The

overall cost of health care programs administered by State agencies was $727.5 million in fiscal year 1988. Each year, these costs are rising.

At the same time, West Virginians continue to get sick more frequently and die earlier in greater numbers than other Americans. For example, studies done by the W.Va. Department of Health over the past several years show that premature deaths from heart disease in West Virginia have been as high as 30% above the national average; deaths due to unintentional injuries, such as automobiles, drownings, and fires, are 18% higher; deaths from lung cancer are 19% higher; diabetes-related deaths are 19% higher; deaths from cancer of the cervix in women are 49% higher; and deaths from lung disease are 27% higher. Our white infant mortality rate is 12% higher than the national average; we were second highest among the fifty states in percentage of births to white teenage mothers, first in the nation in percentage of low birthweight infants born to teenage mothers and third highest in the nation in number of mothers receiving inadequate care. Twenty-eight percent (28%) of our adults are obese, ranking West Virginia first in the nation. We are third highest in adults who smoke; and first in the use of smokeless tobacco. Federal studies show that we have the fifth highest rate of traumatic occupational fatalities in the nation, more than double the national average; and our rate of disability is over 12 per 1000, again ranking us second in the country.

It is little wonder then that, according to a correlation

of West Virginia's per capita income data and the American Hospital Association's 1987 and 1986 State Hospital Statistics Reports, West Virginians spent a greater proportion of their personal incomes (5.64%) in 1987 on hospital care than did the citizens of any other state. This was an increase over 1986 when we were also first with 5.49%. Except that, according to the same AHA Reports, West Virginia's 1987 hospital admissions per 1,000 actually decreased at a rate greater than the national average (-7.2% vs. -3%). West Virginia's rate of 155 per 1,000 versus the national rate of 130 per 1,000 gives us the third highest hospital admission rate in the nation. In 1986 we were second. Our 106 surgical operations per 1,000 gives us the second highest surgery rate in the United States; and in 1986, our outpatient visits were also the second highest per 1,000 in the country.

Even with these high utilization statistics, access to health services for our more rural citizens is inadequate, with 36 of our 55 counties designated entirely as medically underserved areas by the Federal Government, and parts of twelve other counties are so designated. Although there were 35 small and rural hospitals serving the State as late as 1987, five of these have since closed, leaving at least two of their communities with no alternative acute care hospital. Of those remaining, another five are in significant financial difficulty and are at risk of closing. It should be especially noted in West Virginia how essential rural hospitals are in the delivery

of accessible health care to those individuals living outside major urban areas. Their loss may have far wider effects than just the loss of substantial health services. Such a loss can result in the loss of physician services, as well as population, jobs, revenues, and overall community income.

The State's historic involvement in dealing with these problems has been a piecemeal approach, with each program and agency focused on its own objectives. Coordination of services and plans among the State agencies and departments responsible for payment for, or development of, health care services has been poor. In reality, its over $700 million in annual expenditures for health care is capable of having enormous impact, for good or ill, and the State of West Virginia has been paying a high price for an inadequate health care system.

B. BACKGROUND OF SB 576, THE WEST VIRGINIA OMNIBUS HEALTH CARE ACT OF 1989

In 1989, West Virginia lawmakers recognized that an increasing amount of State fiscal resources had been and are dedicated to providing health care for the State's residents. Even with increasing resources, the State has been unable to pay timely for these health services.

The legislation proposed by the current Administration was designed to meet the dual goals of improving the quality and accessibility of health care while achieving cost-savings. The final legislation was the result of intensive negotiation and compromise by Administration officials, legislators, health care providers and public employees. The legislation requires that participating agencies develop a coordinated approach to the provision of quality, accessible and cost effective health care to their beneficiaries. While the new law was technically effective "upon passage", the primary provisions were not to become effective until the participating agencies adopted a plan for implementation of the law.

II. THE PLAN

A. INTRODUCTION

The Omnibus Health Care Act, W.Va. Code S.16-29D-1 et. seq., directs the agencies of State Government involved with the delivery of, or payment for, health care to coordinate their activities to meet three goals:

1. Cost containment
2. Improved access to health care
3. Improved quality of health care.

This initial plan for the implementation of the Act is flexible in order to meet the changing nature of the health care environment. The plan describes:

1. Individual and multi-agency measures presently in effect or under development which will meet these three goals; and

2. Processes by which cooperating agencies will explore and develop additional mechanisms to contain costs, increase accessibility and improve quality of health care services.

The effective date of this plan is September 1, 1989.

B. DESCRIPTION OF PARTICIPATING AGENCIES AND DEPARTMENTS

The Act specifically designates six agencies of State Government to act together with regard to health care payment, policy and planning. These are:

(1) Public Employees' Insurance Agency (PEIA), now a

division of the Department of Finance and Administration.

(2) Department of Human Services (DHS), now a division of the Department of Health and Human Resources.

(3) Workers' Compensation Fund (WCF), now a division of the Department of Health and Human Resources.

(4) Health Department (Health), now a division of the Department of Health and Human Resources.

(5) Division of Rehabilitation Services (DRS), now a division of the Department of Education and the Arts.

(6) Medical schools governed by the Board of Directors of the State College System and the University of West Virginia Board of Trustees (formerly Board of Regents), now under the Department of Education and the Arts.

The services provided by these agencies may be summarized as follows.

The Public Employees Insurance Agency was authorized under the State Code in 1971 and created to provide group hospital and surgical insurance, group major medical insurance, and group life and accidental death insurance for all public employees of the State. Employees are defined as any persons, including elected officials, who are permanent, full-time employees of the State, its colleges and universities, county boards of education, counties, cities or towns, and other individuals and governmental bodies so specified by the Code. Retired employees and some private entities which are supported primarily by counties,

cities or towns are also included. Currently, over 260,000 (one in eight West Virginians) are covered by the PEIA. Enrollment statistics reveal a relatively slow, yet increasing growth in the past seven years, with a substantially increasing proportion of retirees. The benefit plan covers a generous range of inpatient and outpatient medical care services, and includes deductibles and copayments. The agency contracts both claims administration and utilization review, which consists primarily of precertification for inpatient admissions. Some other changes include the imposition of preexisting condition limitations on new enrollees, imposition of premiums on new enrollees and a mandate to create a Wellness Program.

The State medical assistance program, known as Medicaid, is administered by the Division of Human Services under federal guidelines. The opportunity for states to establish a Medicaid program was begun in 1965, as reflected in Title XIX of the Social Security Act. Federal funds, to match with state funds, are available with the federal percentage calculated annually. This is inversely related to a state's per capita income, relative to the national average. West Virginia's fiscal year 1990 percentage is 76.61, the second highest in the nation.

In West Virginia, families who receive public assistance grants and aged, blind, and disabled individuals who receive Supplemental Security Income (SSI) are automatically eligible to receive medical cards for coverage. States can choose to cover other categories of people; most frequently covered are the

medically needy. In West Virginia, this group may include families with children and aged, blind, and disabled adults who would meet all requirements of public assistance if their incomes or assets were below maximums allowed. Only the monthly medical card is issued to anyone determined eligible as medically needy.

Medicaid recipients receiving federally supported financial assistance must have access to the following required services: inpatient and outpatient hospital services; rural health clinic services; laboratory and x-ray services; skilled nursing facility and home health services for those aged 21 and over; physician services; nurse midwife services; family planning services; and early and periodic screening, diagnosis, and treatment for individuals under age 21. States may choose to expand their coverage to include other approved options. West Virginia offers twenty of the thirty-two options, some of which are Intermediate Care Facility (ICF) services, eyeglasses, and prescription drugs. Once determined eligible, recipients are entitled to receive any covered service from any qualified participating provider of medical care. Providers are paid from an established fee schedule. Medicaid is the payor of last resort. Federal regulations require states to identify any third-party resource available to meet the medical expenses of a recipient.

The other medical care service administered by the DHS is the Handicapped Children's Program. This federal and state funded service is responsible for evaluation, treatment, and habilitation of children (under age 21) with chronic,

handicapping or disabling conditions. Services are provided statewide in clinic or specialist care settings, and may include physician care, lab and X rays, medications, equipment and supplies, surgery, and hospitalization. The cost of care is shared by the family's health insurance, Medicaid, or other health care resources. Depending on financial status, families may be required to share in the cost of care.

The Workers' Compensation Fund was created in 1913 to provide coverage for occupational injuries. In 1949, coverage was expanded to include occupational diseases, and in 1969, occupational pneumoconiosis coverage under the Fund became mandatory for nearly all employers in the State. West Virginia's compensation system is one of six programs nationwide which provide exclusive state insurance for workers' compensation coverage.

The Fund provides an income replacement system for injured and disabled workers, compensation for loss of function and full reimbursement for the reasonable costs of medical care and rehabilitation which are associated with a compensable injury or disease. Back problems are, without question, the most common high cost injuries in the compensation system. The Fund pays for medicines, treatment, medical supplies and equipment, and prosthetic appliances. Treatment services may be of a medical, surgical, dental, or hospital nature. Rehabilitation services are also provided. The Fund is authorized to establish a fee schedule for the payment to providers of covered health care

services. Providers have been prohibited for over 20 years from charging injured employees in excess of the amount paid under the established fee schedule.

The Division of Health utilizes both federal and State funds for institutional, hospital and outpatient care. The Office of Community Health Services provides maternity, family planning, pediatric, and dental care. Maternity service fees were set at the Medicaid reimbursement rate and three groups of women are served: first, adolescents, who due to their parents' income are not eligible for Medicaid coverage, are covered for complete maternity services; second, non-citizens, at or below 150% of federal poverty levels, are covered for prenatal care only. Delivery is considered an emergency service and is covered by Medicaid if the non-citizen applies for this coverage within 30 days of delivery and is determined eligible. Third, presumptive coverage provides every pregnant woman an initial maternity examination, necessary laboratory work, or any emergency care, provided that she submit an application to Medicaid and be denied, and submit evidence of Medicaid denial to her provider. Presumptive clients are covered at any income level. Family planning services are available to all women who are at or below 150% of the federal poverty level. The Early Periodic Screening Diagnosis and Treatment Program (EPSDT) is administered through the Division of Health, although the funding source is Medicaid. The Pediatric Health Service Program, like the EPSDT Program, serves children up to age 21, but provides medical screening,

acute care visits, and free medication and vitamins for children whose family income level is at or below 150% of the federal poverty level. A fee schedule is utilized. EPSDT serves approximately 47,000 children, and the Pediatric Health Service Program serves approximately 30,000 children. Preventative and treatment dental services are available for children who fall between Medicaid eligibility and 150% of the federal poverty level. There are currently 5,500 children receiving dental services.

Federal and State funds are also utilized by community behavioral health centers and other contractors for the provision of behavioral health care to children, adolescents, adults, and senior citizens. Broadly stated, the services are crisis resolution, outpatient, residential, case management, and prevention. The State operates behavioral health inpatient facilities and long-term care facilities for those requiring these types of care. For those not eligible for Medicaid funded services, a sliding fee schedule is typically utilized.

Under the Rehabilitation Act of 1973 (as amended) and relevant State law, the Division of Rehabilitation Services can provide or sponsor virtually any service deemed necessary to enable people with handicaps to achieve a rehabilitation objective, including a broad range of health care services. Applicants, aged 15 and above, must have a medically recognized physical or mental disability which results in a handicap to employment and/or independent living to be determined eligible

for services. Applicants may receive diagnostic services to establish the presence of such a disability, and the nature or severity of any resulting handicap. Services may be provided in a clients' community, as well as the Rehabilitation Center at Institute. In FY 88, the Division provided health care services to 8,431 persons. The ability to serve an increasing number of applicants relates to the overall Division budget relative to the cost of health care services. The types of services which may be provided or sponsored to support an eligible person's rehabilitation efforts include the following: diagnostic medical evaluations and services; radiology; pathology; medical treatment; surgery; hospitalization; speech, physical and occupational therapies; orthotics; prosthetics; durable medical equipment; hearing and vision aids; psychiatric therapy; medications. Health care services purchased by the Division must be pre-authorized. A considerable body of policy concerning the provision of health care services and an extensive fee schedule is utilized.

C. DEVELOPMENT AND IMPLEMENTATION OF COORDINATED PLAN

The development and implementation of a fully coordinated plan for health care services pursuant to the Omnibus Health Care Act will be achieved gradually with input from health care providers and consumers. The current plan enumerates the initial phases of joint and coordinated activities for Fiscal Year 1990.

PHASE ONE: Incorporation by Reference of Current Rules, Policies and Practices of Participating Agencies

This is a period of transition for State Government. While implementation of the Omnibus Health Care Act of 1989 proceeds, the agencies designated by the Act cannot abandon their current procedures, rules and practices as they relate to the provision of, or payment for, health care. Therefore, the current rules, practices and policies of the designated agencies are incorporated by reference into this plan, until they are superseded by coordinated actions or rules promulgated pursuant to the Act or other changes by an agency prior to coordinated actions or rules. A summary of current procedures, including current cost containment measures and utilization review procedures, and citations to current Rules, are appended as Attachments B-1 to B-5[3]. The participating agencies intend for the plan to be complementary and consistent with the findings and goals of the State Health Plan, as developed and revised by the Division of Health.

[3] The Attachments are as follows: B-1 PEIA; B-2 Human Services; B-3 Health; B-4 Workers' Compensation; B-5 Rehabilitation Services.

PHASE TWO: Development of Coordinated Agency Work

Five of the designated State health care agencies -- the Division of Health, Division of Human Services, Workers' Compensation Fund, Public Employees' Insurance Agency and Division of Rehabilitation Services -- have embarked upon the coordination of health care services with the following four goals:

1. Ensuring access to care
2. Ensuring effective cost containment
3. Ensuring quality of care
4. Ensuring fairness to providers and consumers.

Senate Bill 576 has been implemented by the development of a joint plan to formulate a combined utilization review and quality assurance program, through the development of contracts by the PEIA with the State's hospitals, through the negotiation of preferred providers contracts by the PEIA with State physicians and others, and through the development of an inter-agency planning committee and a claims processing committee. This initial implementation of the new Act is the beginning of what is expected to be a multi-phase process consisting of careful study followed by equally careful implementation.

Phase Two of the coordinated plan focuses primarily on implementation of Sections 3(e), 3(i) and 4 of the Omnibus Health Care Act. Section 3(e) requires that health care providers who seek reimbursement from any State agency for the provision of services will be regarded as having agreed to accept patients who

are beneficiaries of any State plans. Section 3(i) requires that PEIA, DRS and WCF pay, effective September 1, 1989, health care providers promptly. Section 4 establishes a prohibition on balance billing by providers who seek reimbursement and, as an alternative, encourages the establishment of a preferred provider organization for medical, osteopathic and podiatry services.

In addition, Phase Two of the plan establishes mechanisms for input from health care providers through the statutory advisory committee and the Utilization Management Committee convened by the Division of Health. Finally, the plan establishes committees and task forces of participating agency heads or designees to explore and develop cooperative ventures of the types identified in Section 3(c) of the Act.

Interagency Planning Committee

The interagency planning committee, known also as the Interagency Health Group, is composed of the heads of the various agencies charged with implementing the new Act as well as designated other officials from each of the agencies. It is the charge of this committee to explore and develop cooperative activities among the agencies involved which will lead to greater access to quality health care for the beneficiaries of each agency while seeking to implement effective cost containment measures. During the initial period of the committee's work, it has reviewed the activities of each of the individual agencies and assisted the PEIA in the development of the programs mandated

by the new Act for calendar year 1989. During this initial period, each agency has been expected to maintain its separately functioning health care programs, but each has agreed not to enter into long term arrangements that would preclude its ability to join with the other agencies in similar, but joint, undertakings. The committee is reviewing the various types of programs offered by private vendors in order to ascertain the current state of the industry as well as to evaluate the programs already in place.

Ensuring Access to Care: Section 3(e)

Section 3(e) of the Act guarantees access to care for beneficiaries of all State plans by requiring providers who participate in one plan to participate in all others. In the past, Medicaid beneficiaries have found it difficult to obtain care in certain geographical areas and for certain specialties. In view of the higher level of reimbursement available from the WCF and PEIA programs, providers have lacked an incentive to participate in the Medicaid program as well. The Omnibus Health Care Act requires participation in all, or none, of the programs.

The participating agencies have reviewed the requirements of the Act. The effective date of this provision coincides with the effective date of the promulgation of this plan, together with the emergency rule, governing this provision. A copy of the rule is attached hereto as Attachment C and incorporated herein by reference.

It is the intention of the State agencies to balance

carefully the needs of State beneficiaries for access to care against the needs of providers to control their own practices. The State agencies recognize the need of providers to establish individual patient-physician relationships and to terminate those relationships based upon the judgment of the provider. Under the Act, this plan and the rules promulgated pursuant to Section 3(e), the only actions which violate the Act are those which discriminate against a group of State beneficiaries based upon their category of reimbursement.

Specific attention has been paid in the rule to the concerns of health care providers. These concerns have been expressed in writing and verbally to the heads of the agencies involved in implementation of this Act. In particular, special attention has been paid to any necessary or advisable continuation of care, including obstetrical care and care for terminally ill patients. Concerns expressed by providers regarding the application of Section 3(e) to out-of-state medicaid patients and to providers whose practices are currently closed to new patients are likewise addressed. Specific attention has also been paid to the needs of health care providers to advise patients about the effect of the rule. Allowance has been made for appropriate transfer of care where a provider chooses to opt out of the state system. Perhaps most importantly, an advice mechanism is established to allow providers to request informal rulings from the Secretary of Health and Human Resources regarding the application of this Section to their practices.

The State agencies, pursuant to this Plan, will monitor the effect of the Act upon the ability of State beneficiaries to access health care, both geographically and by specialty. Any resulting decrease in access to care which results from decisions of health care providers to remove themselves from the State system will be studied and reported to the Legislature. The State agencies further will work to encourage the full participation of all categories of providers in the State system by encouraging communication and establishing educational programs to counteract any misconceptions regarding the Act and its implementation. Health care providers are, and will be, encouraged to contact the Inter-agency Health Group by contacting the General Counsel of the PEIA.

Ensuring Containment of Costs

The plan for containment of costs to be acted upon in fiscal year 1990 is as follows:

(1) Implementation of Section 4 of the Omnibus Health Care Act:

Section 4 of the Act provides for two alternative mechanisms for cost-savings. Subsections (a), (b) and (c) provide for the implementation of a fee schedule by PEIA, require assignment of health care payments and prohibit providers from billing the balance of any bill to the beneficiary directly. As a result of negotiation and compromise during the legislative process, Sections 4(d) and 4(e) provide specifically for an alternative means to achieve equivalent cost-savings through direct

negotiations between PEIA and individual hospitals and preferred provider organizations of allopathic and osteopathic physicians and podiatrists.

Upon the date of the filing of the first emergency rule and this plan, the provisions of Section 4 of the Act also become effective September 1, 1989. In the event that Subsections (d) and (e) result in successful negotiations, the provisions of Subsections (a)-(c) will not be implemented for the class of providers covered by the negotiated contract. However, the provisions of subsections (a)-(c) will be effective for any group of providers not covered by a contract negotiated pursuant to subsection (d) or any individual hospital not covered by a contract negotiated pursuant to subsection (e).

It is the intention of the PEIA to maintain fair and reasonable fees, within the confines of the available budget. In order to do so, PEIA has conducted a study of the reasonable and customary charges by Current Procedural Terminology (CPT) code for 1988. A fee schedule, based upon the 80th percentile of that study, will be implemented on September 1, 1989.

WCF and DHS practices are unaffected by the provisions of Section 4 at this time. Both WCF and DHS have instituted fee schedules as a result of their own specific grants of authority. WCF and DHS beneficiaries are protected from balance billing as a result of this same preexisting authority. However, it is the intention of the WCF to act in coordination with the PEIA in the establishing of appropriate and reasonable fee schedules and in

the negotiation of preferred provider contracts. In the longer term, the State agencies will investigate other bases for setting fees, including relative value, cost-based, or resource model fee schedules.

(2) Development of Joint Utilization Review and Quality Assurance Programs:

The State agencies recognize that the development of a fee schedule, and prohibition on balance billing, may control costs without any guarantee of quality. Cost-savings, and quality assurance, may best be guaranteed through strong, effective and consistent utilization review and quality assurance programs.

Recognizing this, the Inter-agency Health Group asked the Director of Health to convene a Utilization Management Committee (UMC) to review and recommend utilization review and quality assurance approaches which will bring West Virginia's programs to the forefront of UR/QA. The UMC is charged with developing a comprehensive plan for the development of peer review/utilization review programs for all affected State agencies. The UMC is studying methods for establishing parameters of care, for establishing appropriate approval and review mechanisms for bill paying, and for establishing the standards of reasonableness to be used for evaluating both the efficacy of the health care delivered as well as for the cost of that care.

Members of the UMC were selected from the various

professional disciplines most affected by discussion of UR/QA. A list of the members of the committee is attached (Attachment D). The UMC began meeting in April 1989, and will report to the Inter-agency Health Group before October 31, 1989. The Health Group has given its commitment to the UMC that the latter group's recommendations will be seriously and purposefully studied before any joint contracts are entered into by the State. The UMC is charged with designing a system that will set the standards and criteria for the specific contracts that the agencies will later develop with private vendors or within State Government itself. Once the report is delivered, the Inter-Agency Health Group will be able to begin crafting joint requests for proposals from interested vendors as well as moving forward with the tasks that can be undertaken by government alone.

The State agencies will continue exploration and implementation of joint and coordinated UR/QA. In particular, consultants from the actuarial firm of Mercer, Meidinger and Hansen are assisting the agencies in developing a proposal for utilization review programs consistent with the recommendations of the UMC. Such programs will be developed for the coordinated program of the State agencies only after a full review of current UR programs currently in use. The joint UR program will address both precertification and review of hospitalization and length of stay as well as review of outpatient procedures. The goal of the UR program will be to provide a high level of <u>appropriate</u> care to the beneficiaries of <u>all</u> State programs.

(3) Review of claims processing and fee schedules to establish coordinated and efficient review of medical bills:

At the time that the Omnibus Health Care Act was passed, the State agencies involved in delivery of, and payment for, health care lacked any coordination. Each agency had developed its own claims processing systems, its own fee schedules and its own review procedures for pended bills. The administrators of these agencies now recognize that this independent approach to bill processing likely has resulted in inefficiencies, duplication and, in many cases, confusion for providers. The administrators now believe that a more efficient and cost effective system may be achievable through coordination and, possibly, centralization of bill processing.

Fee schedule comparisons between DRS, WCF and PEIA are therefore being performed by ERISCO, the private vendor currently responsible for PEIA claims processing. The fee schedule comparison will be used to develop a reasonable and customary fee schedule for use by all State agencies. However, the State agencies recognize that different agencies may continue to pay bills at varying percentile levels of this schedule. Later the Inter-agency Health Group may consider a change in methodologies.

In addition, an interagency task force, with representation from PEIA, DHS, WCF, Health, and DRS is charged with the task of evaluating and comparing all aspects of medical fee bill processing currently performed by the agencies or their private

vendors. The charge to this task force is attached as Attachment E. The task force will make its initial report, regarding the comparison of the existing systems and the areas amenable to coordination, before September 30, 1989. The agencies involved will then begin to design and implement coordinated plans in this area.

(4) Joint and cooperative agency involvement in proceedings before the Health Care Cost Review Authority:

The three primary State payor agencies (PEIA, WCF and DHS) will assert the State's interest in cost-effective, quality health care by intervening in appropriate proceedings involving Certificates of Need and rate review before the Health Care Cost Review Authority (HCCRA). The goal of such intervention in HCCRA proceedings is to represent the interests of the State agencies in cost savings and health promotion as well as the interests of the State's beneficiaries in accessible, quality health care. Intervention will not be pursued in every proceeding. Rather, the agencies will analyze the potential impact of each proceeding upon the provision of care to the beneficiaries of these State plans. The factors to be considered will focus on the dual objectives of cost effectiveness and the availability of high quality health care to State beneficiaries.

Ensuring Quality of Care

(1) Utilization Review and Quality Assurance

Utilization Review is not simply a mechanism for cost savings, although it will save costs. It is also the mechanism for establishing a standard of high quality care for all State beneficiaries. The development of state-of-the-art peer review utilization programs will assist the State agencies in monitoring the quality of care provided to all beneficiaries. The agencies will also work in cooperation with HCCRA and UMC in developing utilization review analyses which will best ensure the availability of high quality health care.

(2) Medical school involvement in development of quality assurance guarantees

The Administrator of Health is also the Vice Chancellor of Health Affairs for higher education. This new link between the medical schools and the State agencies provides an important potential for the development of quality assurance in peer review and in rural settings. Implementing this plan, the agencies will cooperate with the medical schools for the purpose of achieving cooperative and coordinated approaches to the provision of high quality and accessible care to beneficiaries under this plan.

Ensuring Fairness to Providers

(1) Implementation of prompt pay provisions of Section 3(i)

Effective September 1, 1989, any uncontested and legitimate medical fee bill received by any of the State agencies, other than DHS, will be paid in sixty-five (65) days or less. Any bill received for payment which is incomplete will be paid within sixty-five days of when the necessary information is provided to the agency. Bills for unauthorized services, or services which exceed the norms of care established by the UR program of the agency, will be paid only in the event that the services provided are subsequently approved for payment through utilization or other similar review. In this case, such bills will be paid within sixty-five days of approval. Any legitimate and uncontested bill paid after sixty-five days will include interest at the current rate, as determined by the State Tax Commissioner, in accordance with Section 16-29D-3(i) of the Act.

The Division of Human Services is excluded from these prompt pay provisions because they are likewise excluded by the Act from these provisions. Federal law prohibits the use of Medicaid monies for the payment of interest in situations such as this. It is, however, the intention of the State agencies to pay bills submitted to the Medicaid program as promptly as the budget of that program will allow.

(2) Keeping the lines of communication open:

-- Informal comment

Comment from all sectors of the health care community is being sought on each aspect of implementation of this plan and the rules promulgated under the Act. Letters soliciting comments have been widely circulated in these communities. The Administrators of PEIA, DHS, and WCF, and the Secretary of Health and Human Resources, are conducting public forums regarding implementation of the Act in Charleston, Bluefield, Wheeling, Martinsburg, Morgantown, Parkersburg and other cities between June and September, 1989. The agencies seek additional and on-going public comment, which is to be submitted to the General Counsel for the Inter-Agency Health Group, c/o PEIA.

-- Formal comment on rules

In accordance with the Administrative Procedures Act, formal comments are sought on all rules through public hearing and written comment. The time and place of hearings and procedures for submission of comments will be widely circulated.

-- Advisory Committee

In accordance with Section 16-29D-7, the Governor has appointed an advisory committee consisting of health care providers and beneficiaries to advise and assist in the establishment of reasonable payment methods and rates. A list of the committee members is attached (Attachment F). The advisory committee may also be asked to provide advice and assistance on

other aspects of implementation of the Act.

-- Utilization Management Committee

As discussed above, the Utilization Management Committee consists of a diverse group of West Virginia health care providers who have been asked, on a volunteer basis, to assist the State agencies in the development of peer review and utilization review plans.

Enforcement and Penalties

The Omnibus Health Care Act provides for the assessment of civil penalties against health care providers when the Act is violated. In keeping with the stated goals of the legislation and fundamental principles of fairness, the Emergency Rule appended hereto clarifies that enforcement actions will not be brought based upon isolated or undocumented complaints against providers. With regard to the agreement to treat beneficiaries from all State programs or with regard to the prohibition against balance billing, only a pattern of abuse will lead to the recommendation that penalties be sought. The Secretary of Health and Human Resources is responsible for the assessment of any civil penalty or the removal of a provider from the list of providers for whose services an agency may pay. Written notice of any enforcement action will be provided to the health care provider, and full procedural rights and protections will be afforded, pursuant to Section 16-29D-8.

The need to achieve the dual objectives of cost-savings and

increased accessibility means that any activities of health care providers that may be in violation of the provisions of Section 16-29D-6 will be closely monitored. Providers will be informed if their activities are viewed as potential violations of this section. Any agreement among providers to withhold services from State beneficiaries, or with the effect of fixing, controlling or maintaining charges or for the purpose or with the effect of defeating the purposes of the Act will be deemed unlawful. Such activities would tend to defeat the purposes of the new law and will be pursued vigorously under the auspices of the Secretary.

Rules to Implement the Omnibus Health Care Act

In conjunction with this plan, the Secretary of Health and Human Resources will promulgate three emergency rules designed to implement the critical elements of the Act:

(1) Implementation of Section 3(e) and related provisions: An emergency rule addressing the implementation of the "take one take all" provisions of the Act, together with the enforcement procedures for Section 3, will be promulgated on an emergency basis together with this plan. The rule has been circulated widely to health care providers to ensure that the specific concerns regarding the election of the option to remain in the State system, or to withdraw from it, are met. A copy of this rule is attached and incorporated herein by reference (Attachment C).

(2) Implementation of Section 4 and related provisions:

An emergency rule will be developed and promulgated to explain the policies and procedures for implementation of Section 4 of the Act. This rule will be developed and implemented in stages. The first part of the rule will be promulgated on or before September 1989. This part will address the implementation of the fee schedule, assignment procedures and prohibition on balance billing for PEIA beneficiaries. In addition, either this first part or subsequent parts of the rule will establish the specific parameters for the preferred provider organization and hospital contracts established pursuant to Sections 4(d) and 4(e), and other issues relating to implementation of Section 4 by the PEIA. In subsequent amendments to the rule, one or more of the other agencies participating in the plan may adopt or modify measures relating to their agencies of the kind made applicable by Section 4 to the PEIA; i.e., preferred provider arrangements, prohibition on balance billing, and fee schedules.

(3) The Secretary of Health and Human Resources is promulgating a procedural rule governing administrative hearing processes for any matters which require hearings under the rules or Act, together with this plan. The rule is attached and incorporated herein by reference as Attachment G.

Future Planning

This plan is an initial formulation of necessary preliminary work under the Act. Fiscal Year 1990 carries specific challenges: to contain costs without jeopardizing the quality of health care available to beneficiaries of West Virginia State health care

programs. The Inter-agency Health Group acknowledges, however, that the needs confronting the health care system of West Virginia are more extensive than those which are addressed in this preliminary plan. Therefore, the designated agencies will develop a plan for the fuller implementation of Section 3 of the Act before July 1, 1990.

Conclusion

This plan describes the implementation of the Omnibus Health Care Act of 1989. As a result of this Act, State agencies are now able to coordinate their activities relating to health care. In keeping with the legislative mandate of the Act, this coordinated approach will produce cost savings for the State while promoting high quality and accessible health care.

ATTACHMENTS

A. A-1: W.Va. Level of Uncompensated Care
   A-2: W.Va. Hospitals' Level of Uncompensated Care
   A-3: Hospital CPI
   A-4: Medicaid Program Costs
   A-5: WCF Medical Costs 1982-1987
   A-6: Health Insurance Coverage by Type of Insurance

B. Current policies, rules, cost containment measures and utilization review system for:

   B-1: PEIA
   B-2: DHS
   B-3: Health
   B-4: WCF
   B-5: DRS

C. Emergency Rule, Section

D. UMC members

E. Interagency claims processing committee: charge to committee

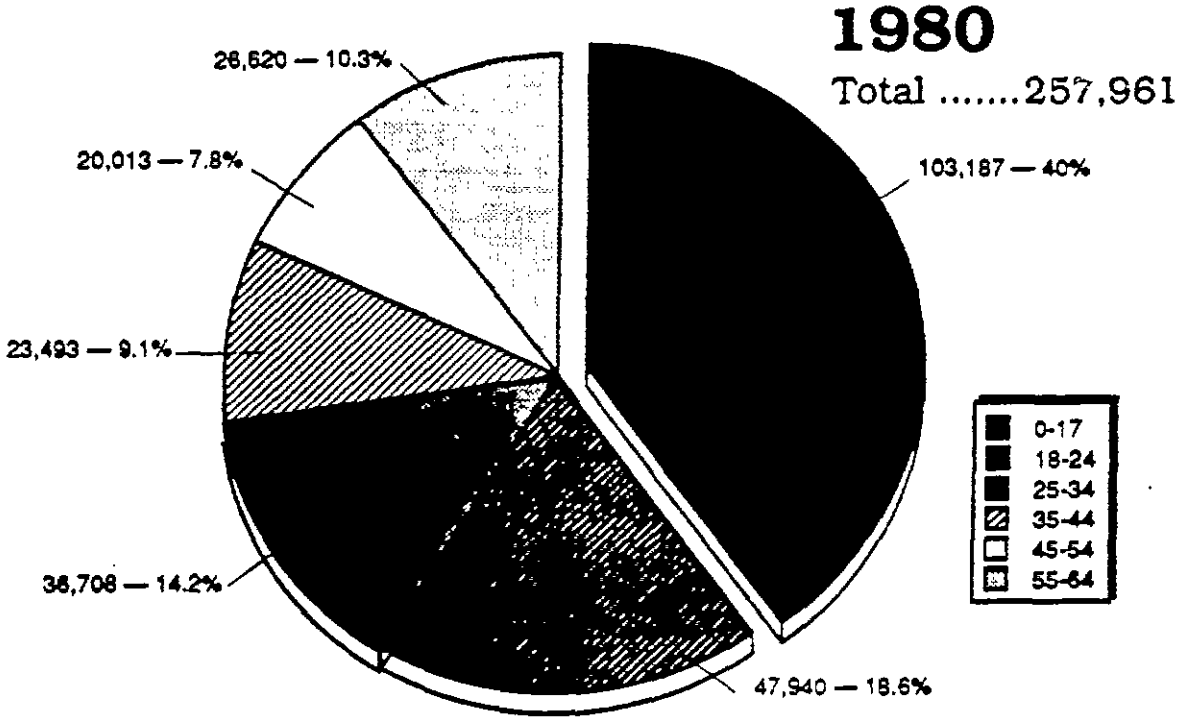
F. Advisory Committee members

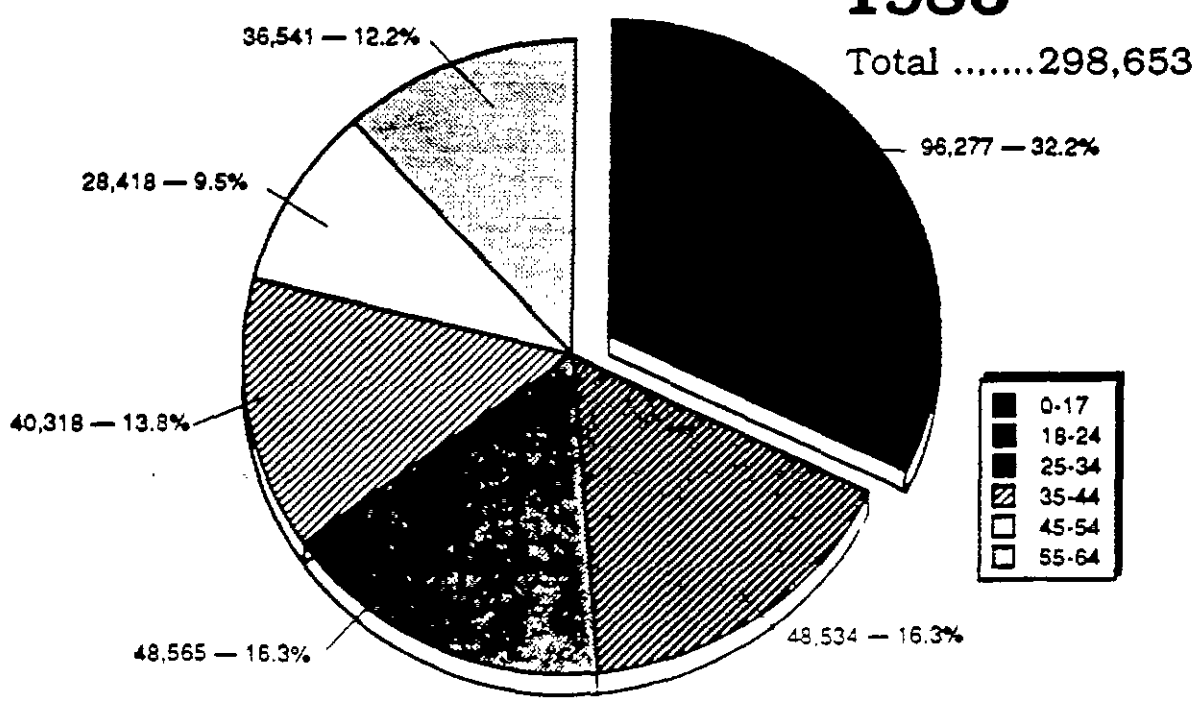
G. Procedural rule governing hearings

Chart 1

West Virginia 1980 and 1986

Age distribution of uninsured persons



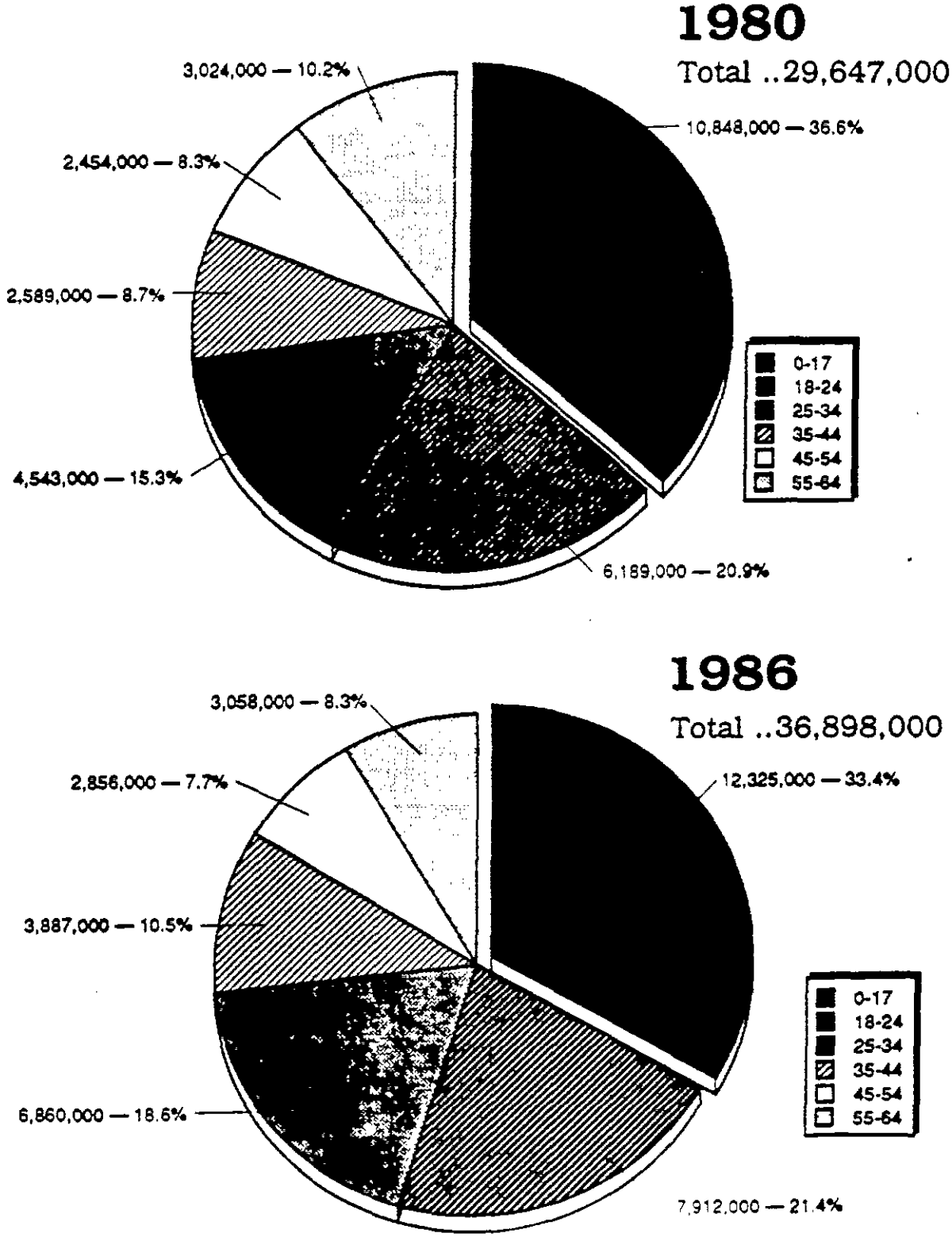


ATTACHMENT A-1a

Chart 2

United States 1980 and 1986

Age distribution of uninsured persons



ATTACHMENT A-1b

Insurance by age groups

West Virginia — 1980

Insurance by age groups

Age	Insured	Uninsured	%
0-17	451,885	103,187	18.6
18-24	180,067	47,940	21.0
25-34	281,541	36,708	11.5
35-44	167,916	23,493	12.3
45-54	187,601	20,013	9.6
55-64	178,806	26,620	13.0
65+	212,927	12,731	5.6
Total	**1,660,742**	**270,691**	**14.0 %**

West Virginia — 1986

Insurance by age groups

Age	Insured	Uninsured	%
0-17	388,890	96,277	19.8
18-24	125,203	48,534	27.9
25-34	235,509	48,565	17.1
35-44	208,412	40,318	16.2
45-54	150,278	28,418	15.9
55-64	192,650	36,541	15.9
65+	293,730	2,144	.7
Total	**1,594,673**	**300,797**	**15.9 %**

United States — 1980

Insurance by age groups
(Thousands)

Age	Insured	Uninsured	%
0-17	52,785	10,848	17.1
18-24	22,930	6,189	21.3
25-34	32,072	4,543	12.4
35-44	22,837	2,589	10.2
45-54	20,245	2,454	10.8
55-64	18,452	3,024	14.1
65+	23,366	828	3.4
Total	**192,687**	**30,475**	**13.7 %**

United States — 1986

Insurance by age groups
(Thousands)

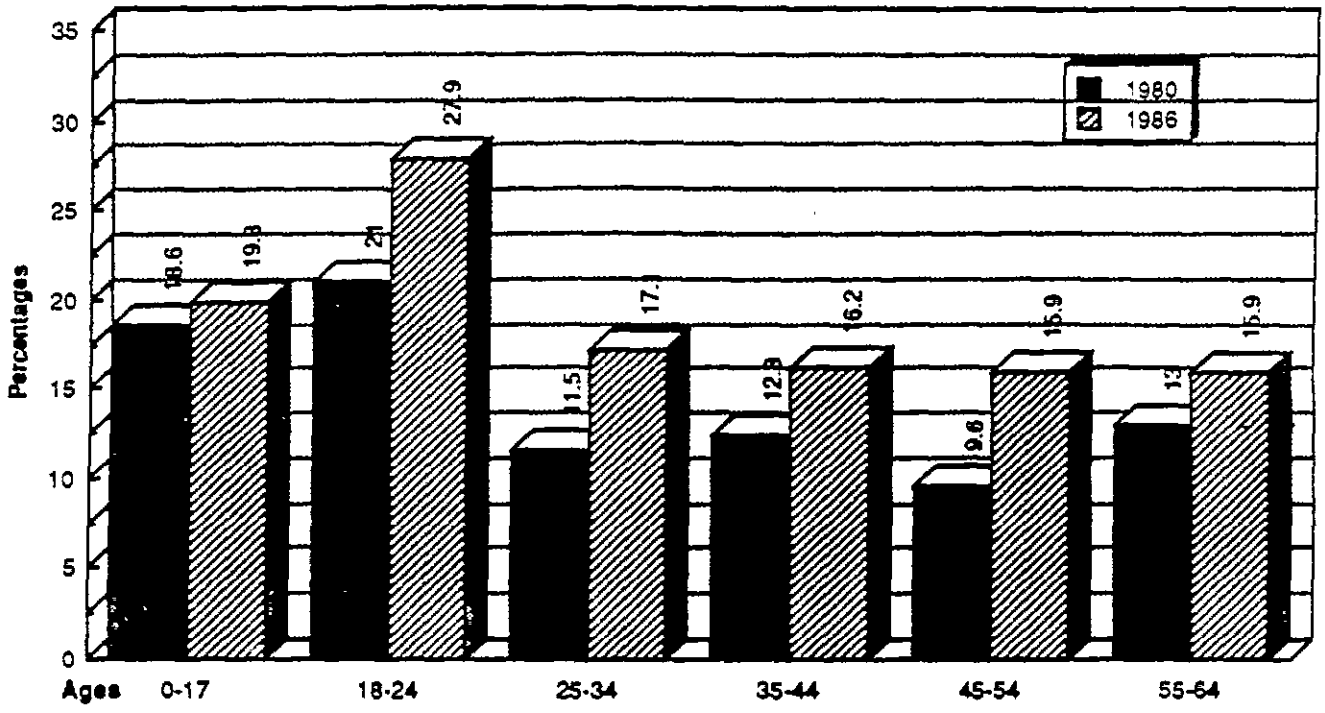
Age	Insured	Uninsured	%
0-17	50,707	12,325	19.6
18-24	19,200	7,912	29.2
25-34	35,193	6,860	16.3
35-44	28,621	3,887	12.0
45-54	19,806	2,856	12.6
55-64	19,004	3,058	13.9
65+	27,038	284	.8
Total	**199,569**	**37,182**	**15.7 %**

ATTACHMENT A-1c

Chart 3

West Virginia 1980 and 1986

Percentage of each age group uninsured

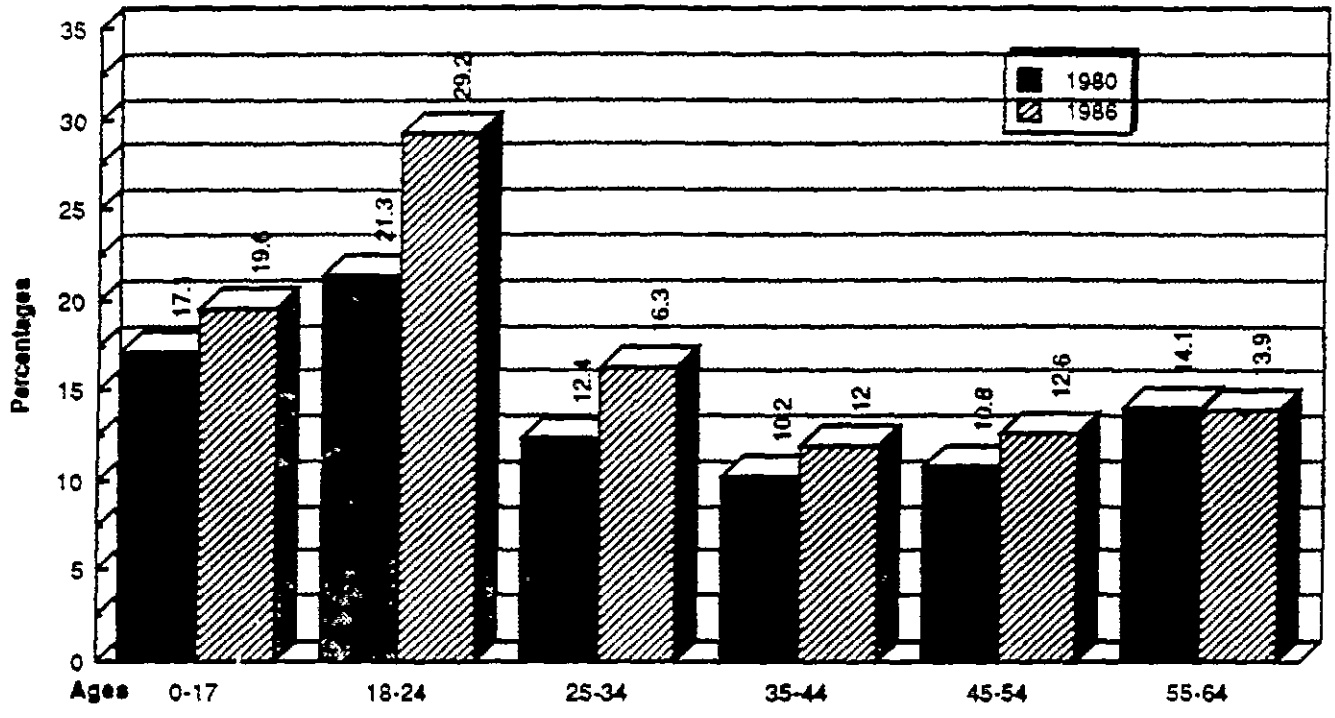


ATTACHMENT A-1d

Chart 4

United States 1980 and 1986

Percentage of each age group uninsured

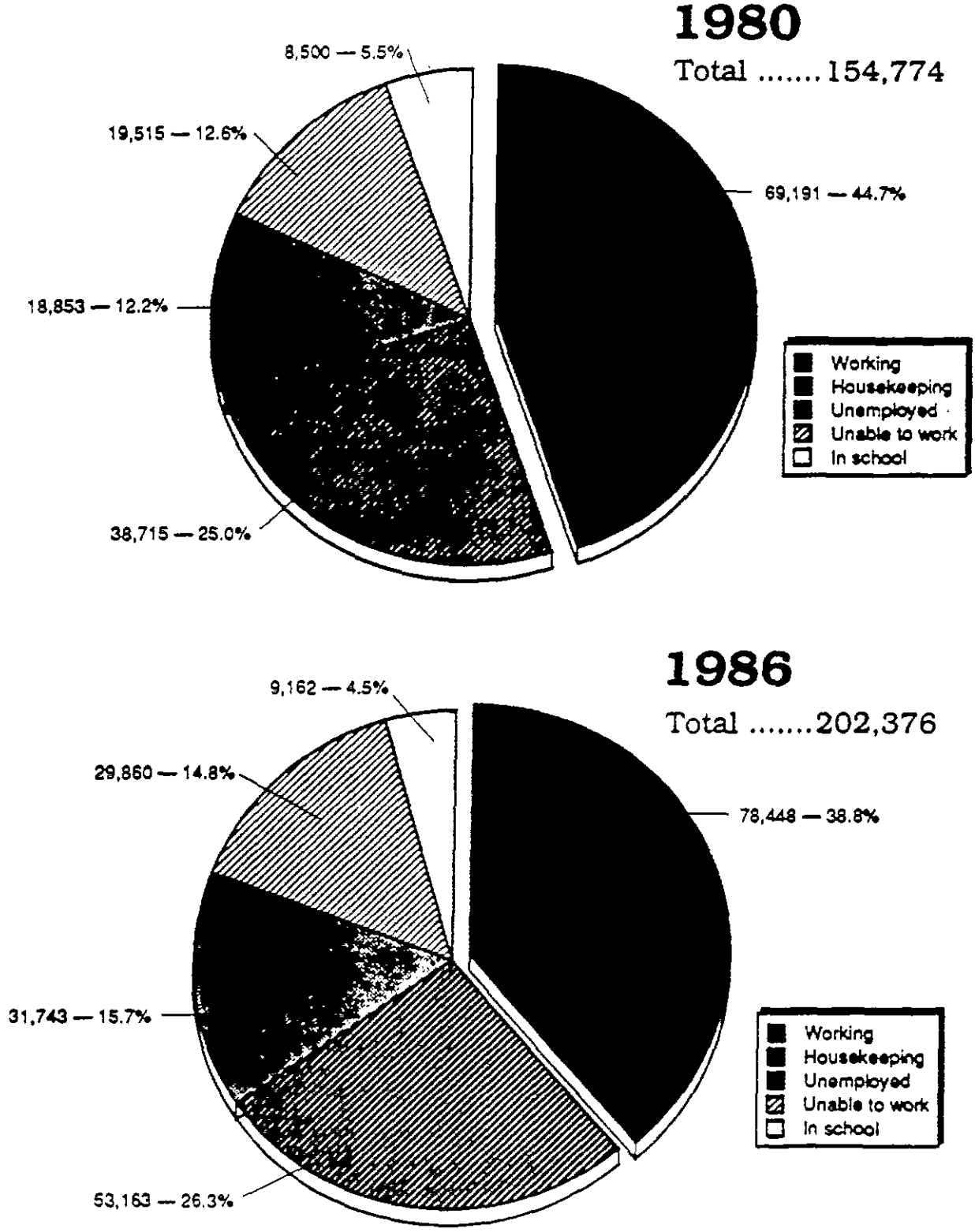


ATTACHMENT A-1e

Chart 5

West Virginia 1980 and 1986

Work status of uninsured adults ages 18-64



ATTACHMENT A-16

Table 2

Insurance by work status

West Virginia — 1980

Ages 18-64
Insurance by work status

	Insured	Uninsured	%
Working	580,261	69,191	10.7
Housekeeping	264,379	38,715	12.8
Unemployed	52,143	18,853	26.6
Unable to work	75,240	19,515	20.6
In school	23,908	8,500	26.2
Total	**995,931**	**154,774**	**13.5 %**

West Virginia — 1986

Ages 18-64
Insurance by work status

	Insured	Uninsured	%
Working	522,203	78,448	13.1
Housekeeping	206,561	53,163	20.5
Unemployed	55,195	31,743	36.5
Unable to work	95,226	29,860	23.9
In school	31,567	9,162	22.5
Total	**910,752**	**202,376**	**18.2 %**

United States — 1980

Ages 18-64
Insurance by work status
(Thousands)

	Insured	Uninsured	%
Working	81,887	10,536	11.4
Housekeeping	18,712	3,435	15.5
Unemployed	4,714	1,625	25.6
Unable to work	6,447	1,868	22.5
In school	3,886	1,335	25.6
Total	**115,646**	**18,799**	

United States — 1986

Ages 18-64
Insurance by work status
(Thousands)

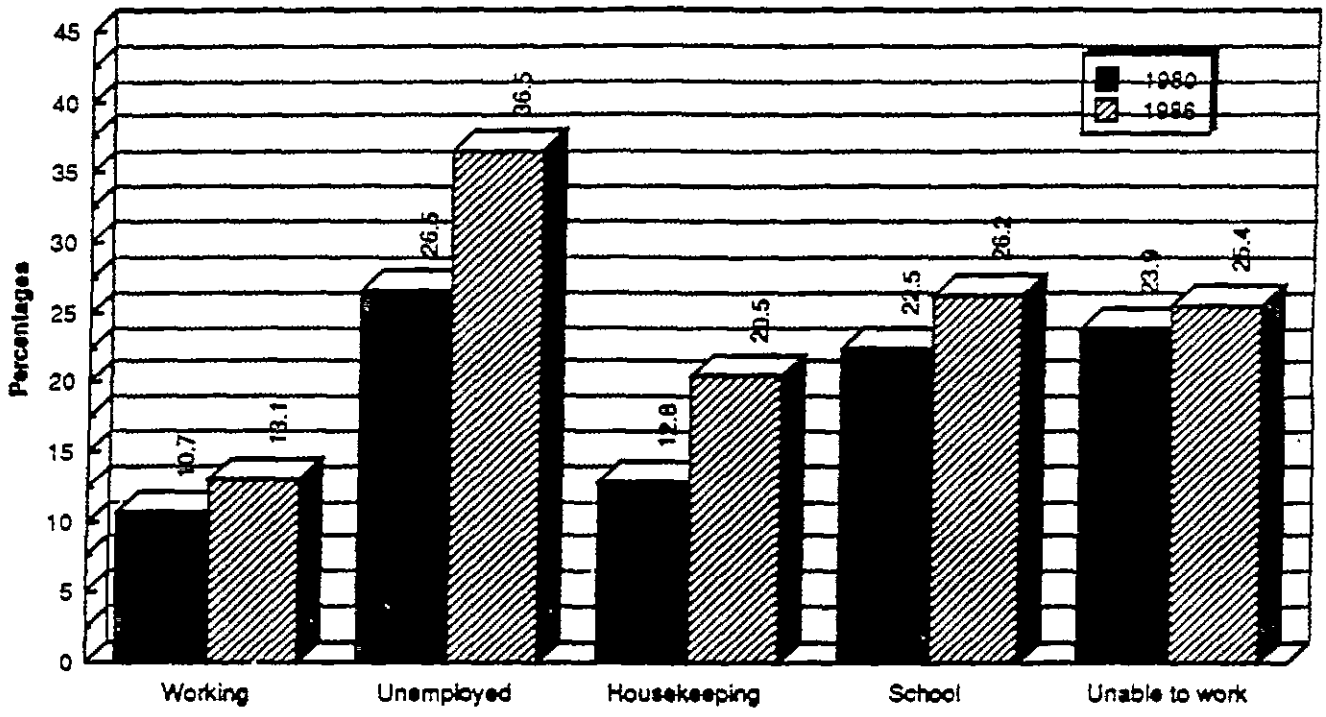
	Insured	Uninsured	%
Working	87,605	14,533	14.2
Housekeeping	16,145	3,630	18.4
Unemployed	5,401	2,591	32.4
Unable to work	7,882	2,298	22.6
In school	3,701	1,520	29.1
Total	**120,734**	**24,572**	

ATTACHMENT A-1g

Chart 7

West Virginia 1980 and 1986

Percentage of uninsured and work status

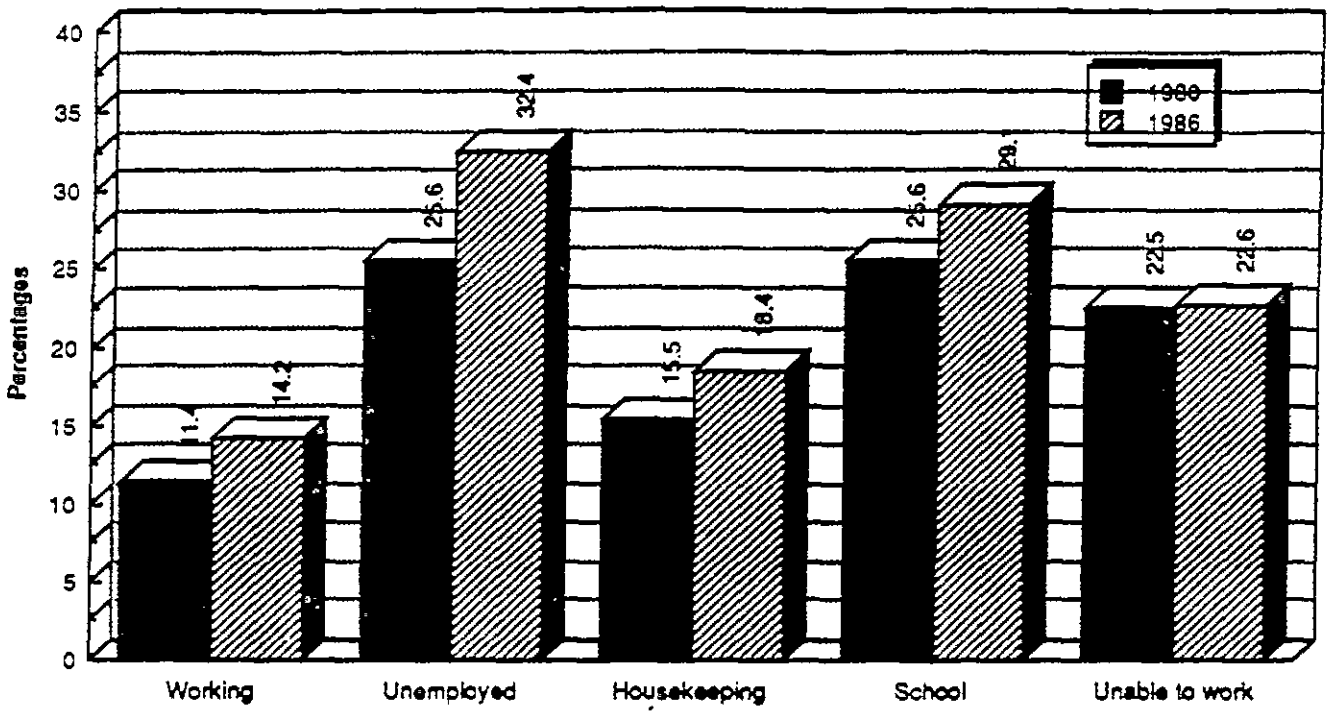


ATTACHMENT A-1h

Chart 8

United States 1980 and 1986

Percentage of uninsured and work status



ATTACHMENT A-11

Table 3

Health insurance coverage by type of insurance

Selected states – Ages 0-64 – 1986

State	Total Number	Percent Private Insurance	Percent Employer Provided	Percent Public Insurance	Percent Medicaid	Percent & Number Uninsured Persons	
West Virginia	1,571,000	68.4%	58.3%	17.9%	13.0%	18.6%	292,000
Virginia	4,549,000	76.4	70.7	10.0	5.2	16.6	754,000
Kentucky	3,001,001	72.3	62.0	10.7	6.7	21.2	638,000
Maryland	3,641,000	77.9	69.8	10.0	6.0	15.0	546,000
North Carolina	5,066,000	77.1	69.2	10.9	4.3	16.3	824,000
South Carolina	2,713,000	76.6	68.8	12.9	7.9	14.4	392,000
United States	199,765,000	73.9	66.0	12.0	8.0	17.4	34,759,000

Source: Employee Benefit Research Institute analysis of March, 1986, Current Population Survey

Notes: These data exclude agricultural workers and military personnel and therefore are not comparable to other tables. Details may not add because of rounding and duplicate counts.

ATTACHMENT A-1j

Non-agricultural workers by industry

with insurance and rates of employment growth 1980 to 1985 — United States

Industry	Number of Workers	Percent of Workers	Employment Growth	Percent Insured
Mining	939,000	0.9%	-4.1%	88.8%
Manufacturing	20,879,000	20.2	-4.8	88.2
Transp. Comm & Utilities	7,548,000	7.3	15.7	87.5
Fin., Insur. Real Estate	7,005,000	6.8	16.9	86.1
Wholesale trade	4,341,000	4.2	10.7	84.1
Professional services	21,563,000	20.9	8.6	81.7
Public administration	4,995,000	4.8	-6.5	87.6
Construction	6,987,000	6.8	12.4	66.2
Retail trade	17,955,000	17.4	10.4	63.7
Business & repair service	5,321,000	5.2	60.6	66.0
Personal services	4,352,000	4.2	13.4	50.3
Entertainment and recreation	1,278,000	1.2	22.1	59.4
Total	103,163,000	100%	17.0%	62.9%

Source: Employee Benefit Research Institute CPS 1986 Tabulation

ATTACHMENT A-1k

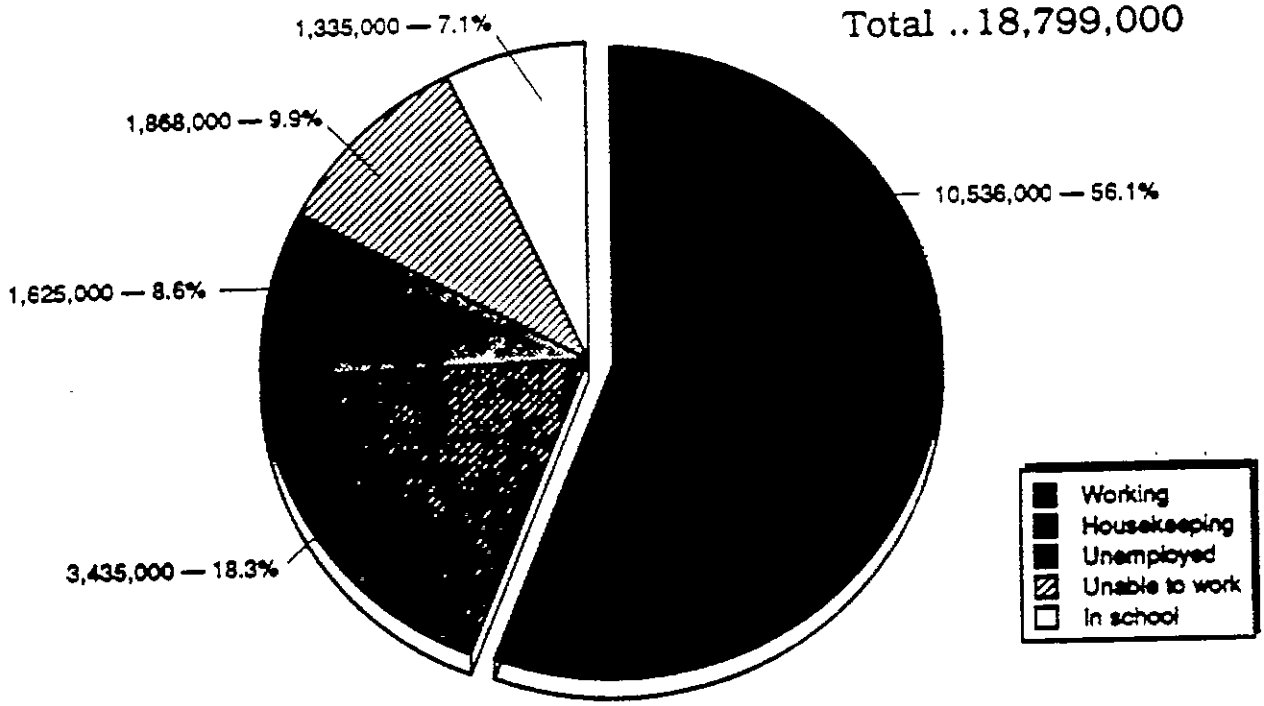
Chart 6

United States 1980 and 1986

Work status of uninsured adults ages 18-64

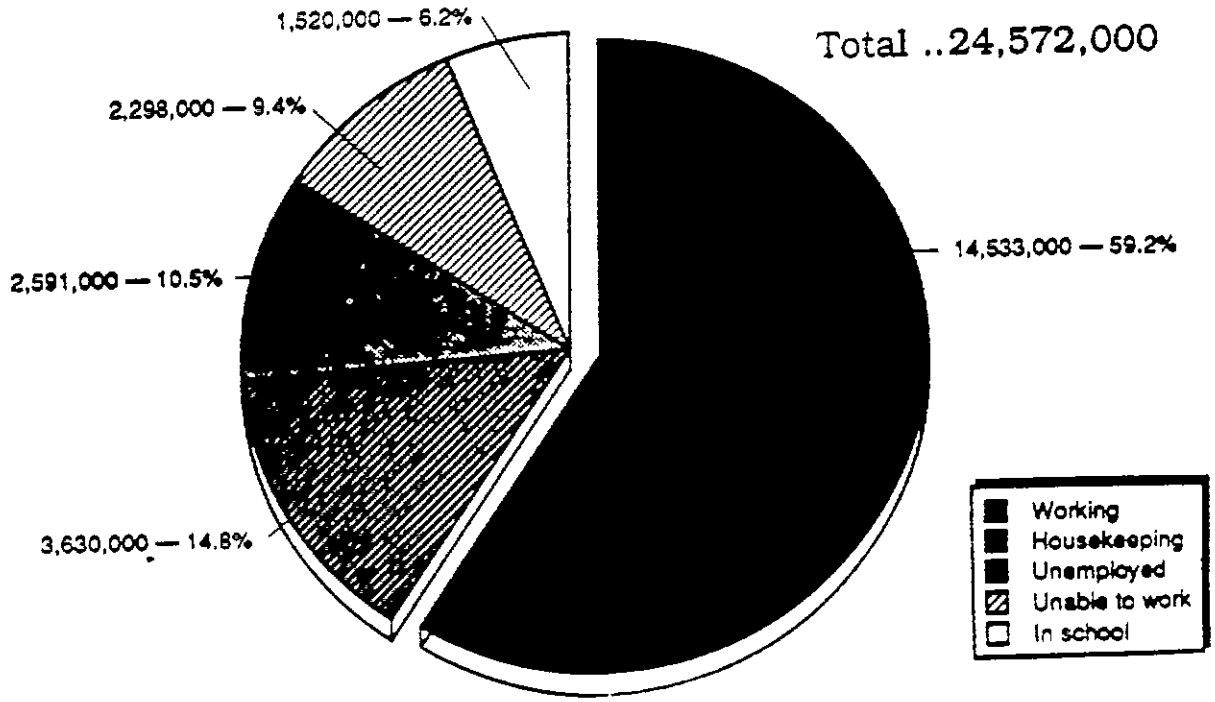
1980

Total ..18,799,000



1986

Total ..24,572,000

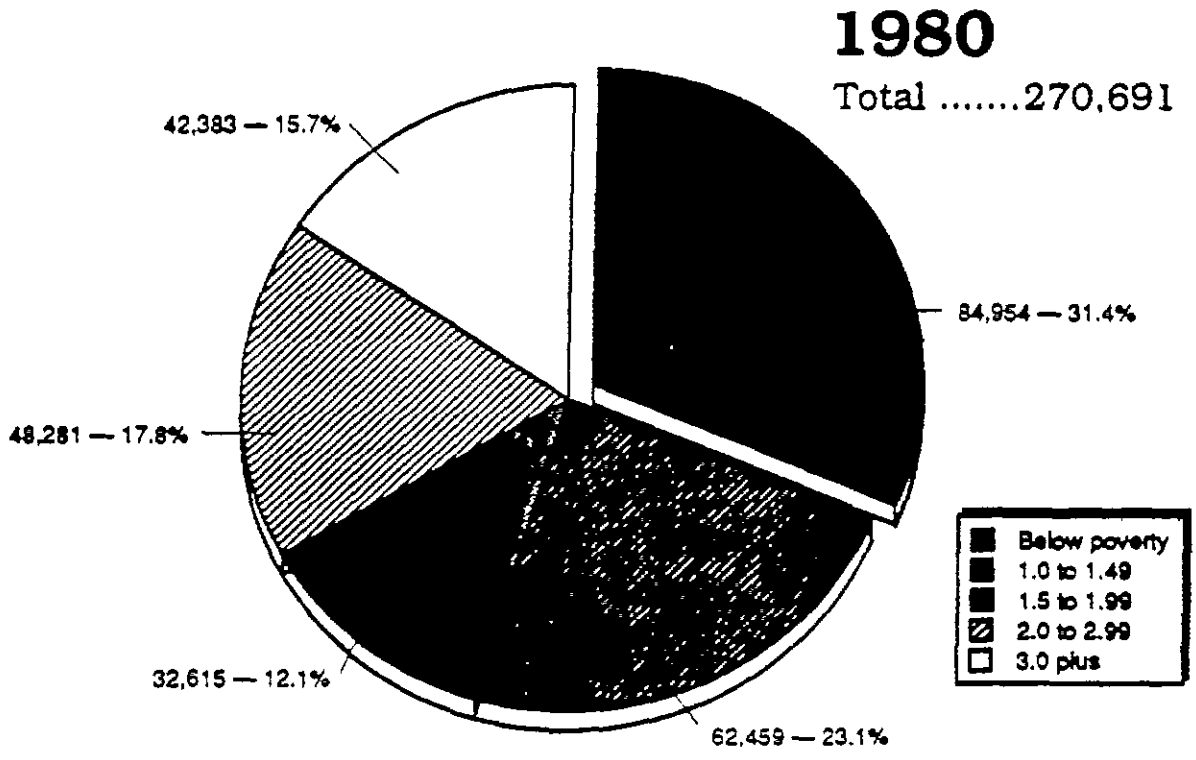


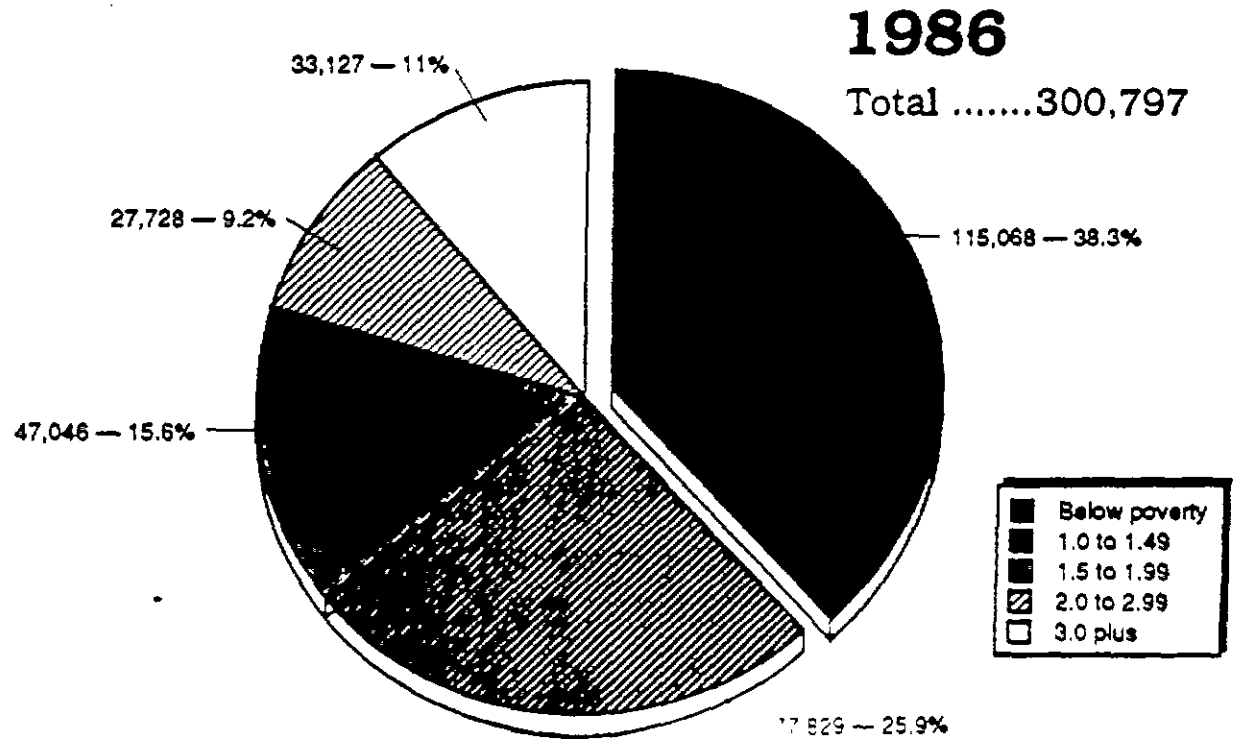
ATTACHMENT A-1

Chart 9

West Virginia 1980 and 1986

Poverty level and the uninsured



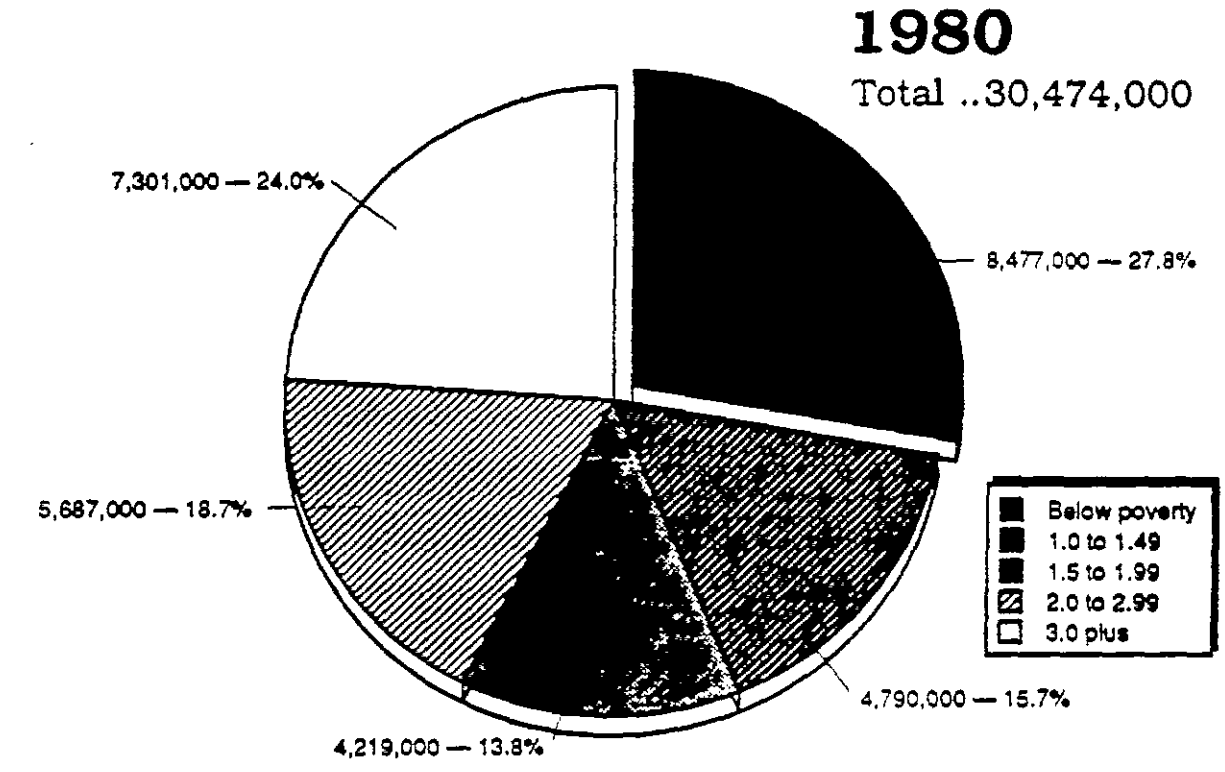


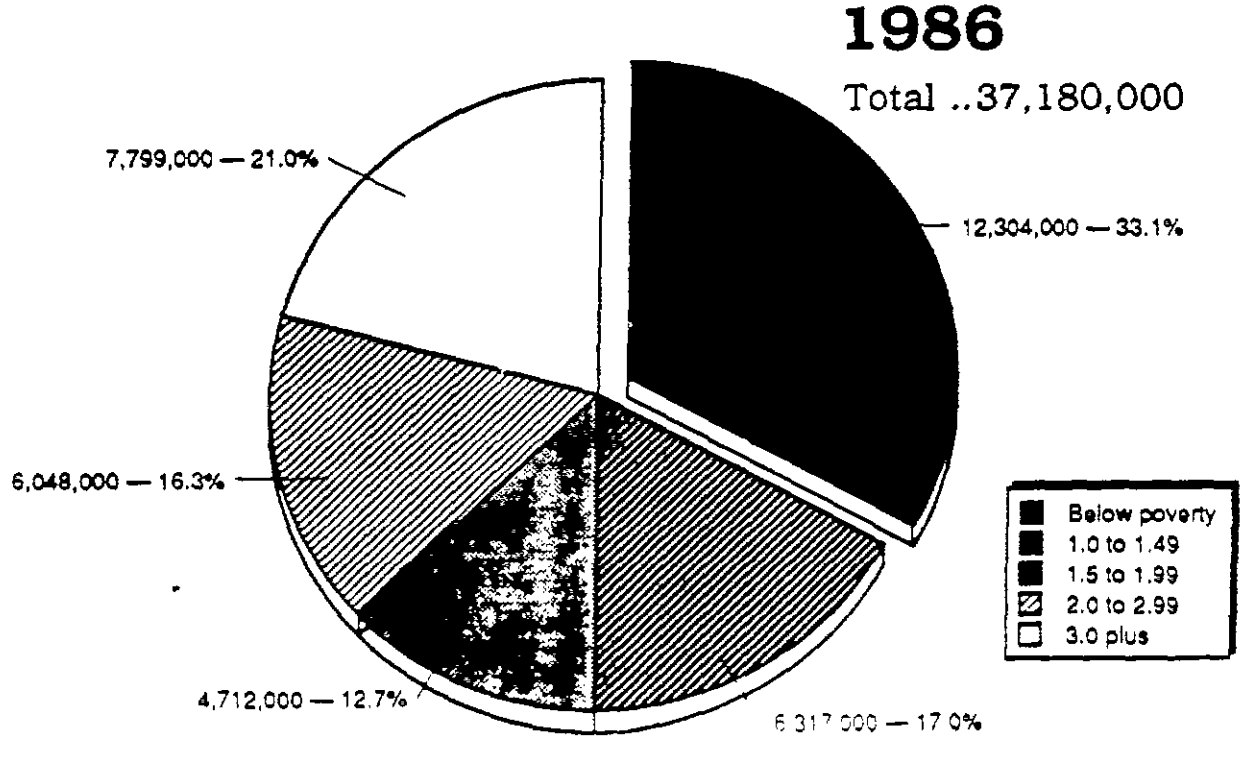
ATTACHMENT A-1m

Chart 10

United States 1980 and 1986

Poverty level and the uninsured





ATTACHMENT A-1n

Table 5

Insurance by income

West Virginia — 1980

Insurance by income

Income	Insured	Uninsured	%
Below poverty	197,242	84,954	30.1
1.0-1.49	152,667	62,459	29.0
1.5-1.99	238,363	32,615	12.0
2.0-2.99	480,660	48,281	9.1
3.0 —	591,811	42,383	6.7
Total	**1,660,742**	**270,691**	**14.0 %**

West Virginia — 1986

Insurance by income

Income	Insured	Uninsured	%
Below poverty	320,913	115,068	26.4
1.0-1.49	208,889	77,829	27.1
1.5-1.99	215,540	47,046	17.9
2.0-2.99	335,991	27,728	7.6
3.0 —	513,440	33,127	6.1
Total	**1,594,673**	**300,797**	**15.9 %**

United States — 1980

Insurance by income
(Thousands)

Income	Insured	Uninsured	%
Below poverty	18,747	8,477	31.1
1.0-1.49	16,118	4,790	22.9
1.5-1.99	18,702	4,219	18.4
2.0-2.99	42,341	5,687	11.8
3.0 —	96,779	7,301	7.0
Total	**192,687**	**30,474**	

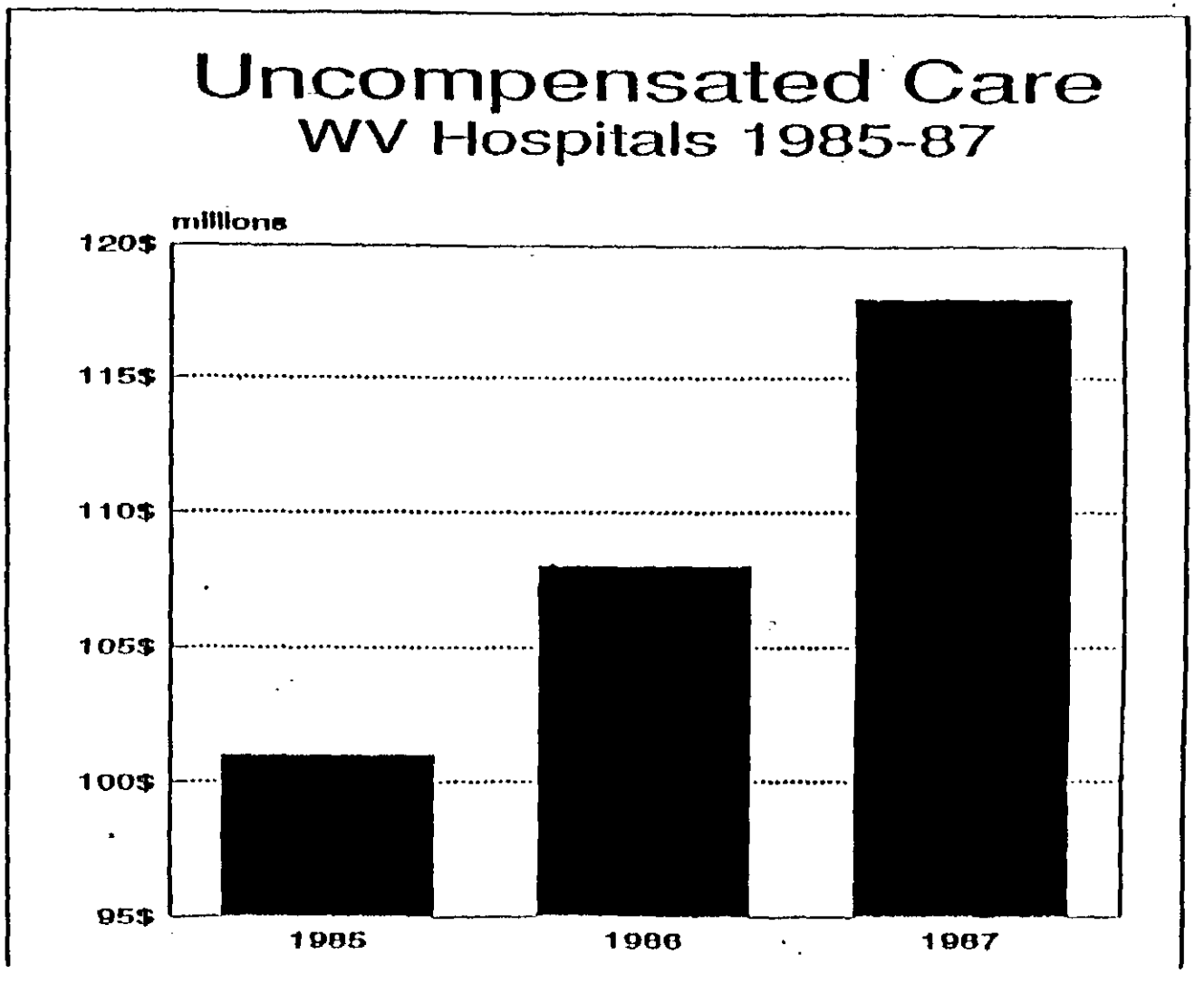
United States — 1986

Insurance by income
(Thousands)

Income	Insured	Uninsured	%
Below poverty	22,855	12,304	35.0
1.0-1.49	16,956	6,317	27.1
1.5-1.99	18,843	4,712	20.0
2.0-2.99	40,924	6,048	12.9
3.0 —	90,094	7,799	7.2
Total	**189,672**	**37,180**	

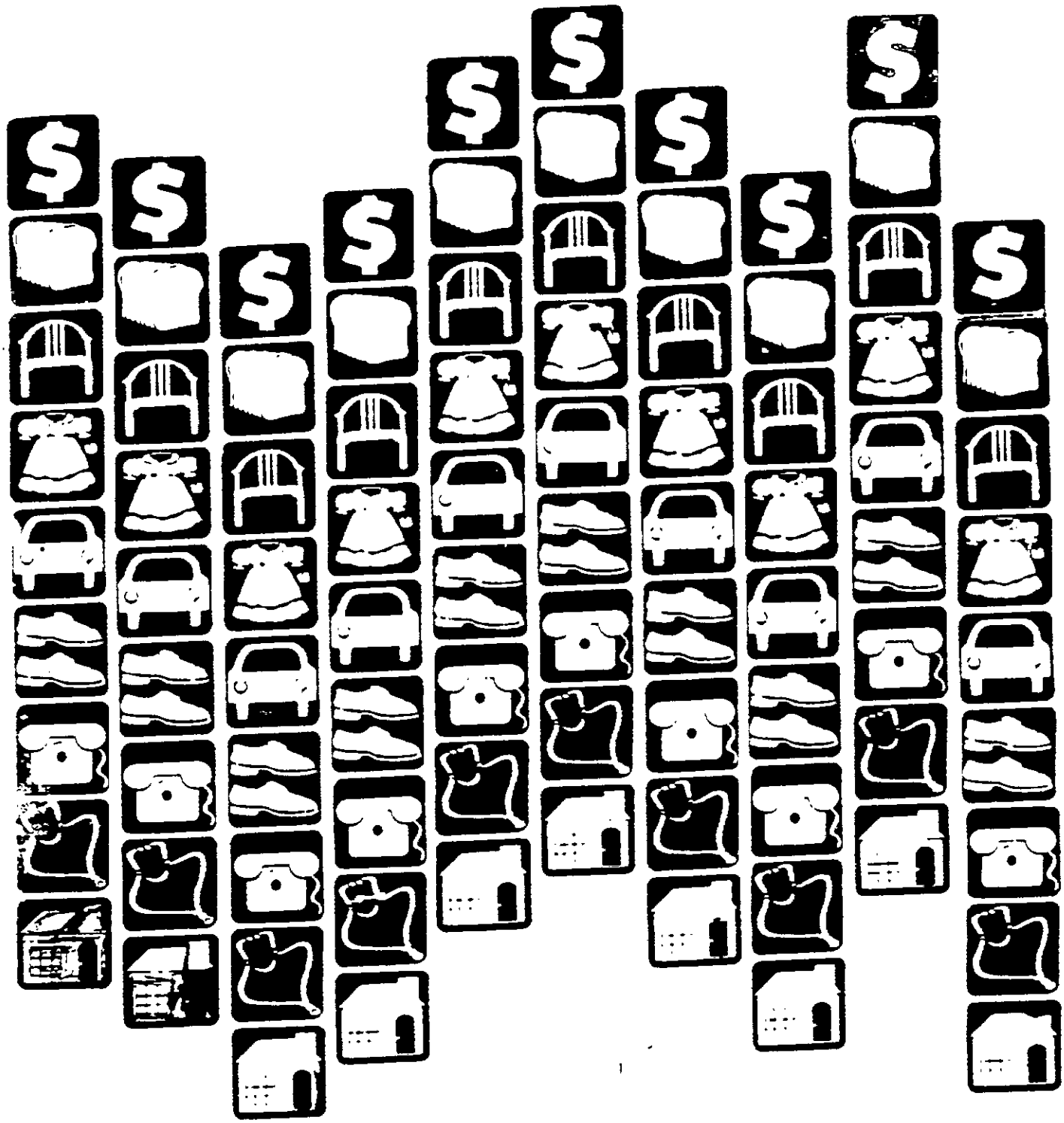
ATTACHMENT A-1o

Care for the Medically Indigent



CPI Detailed Report
December 1988

U.S. Department of Labor
Bureau of Labor Statistics



ATTACHMENT A-3a

Table 3. Historical Consumer Price Index for All Urban Consumers (CPI-U) and Urban Wage Earners and Clerical Workers (CPI-W): U.S. city average, major groups

Year and month	CPI-U								CPI-W
	All items	Food and beverages	Housing	Apparel and upkeep	Transportation	Medical care	Entertainment	Other goods and services	All items
	Indexes 1982-84 = 100								
1952, Dec.	26.7	-	-	43.1	26.3	17.0	-	-	26.9
1953, Dec.	26.9	-	-	43.4	26.3	17.6	-	-	27.0
1954, Dec.	26.7	-	-	43.1	25.9	18.0	-	-	26.9
1955, Dec.	26.8	-	-	43.3	25.9	18.6	-	-	27.0
1956, Dec.	27.6	-	-	44.4	27.1	19.2	-	-	27.8
1957, Dec.	28.4	-	-	44.8	28.3	20.1	-	-	28.6
1958, Dec.	28.9	-	-	44.9	29.4	21.0	-	-	29.1
1959, Dec.	29.4	-	-	45.5	30.3	21.8	-	-	29.5
1960, Dec.	29.8	-	-	46.2	29.8	22.5	-	-	30.0
1961, Dec.	30.0	-	-	46.4	30.4	23.2	-	-	30.2
1962, Dec.	30.4	-	-	46.7	31.0	23.7	-	-	30.6
1963, Dec.	30.9	-	-	47.5	31.3	24.3	-	-	31.1
1964, Dec.	31.2	-	-	47.7	31.7	24.8	-	-	31.4
1965, Dec.	31.8	-	-	48.3	32.0	25.5	-	-	32.0
1966, Dec.	32.9	-	-	50.2	32.7	27.2	-	-	33.1
1967, Dec.	33.9	35.3	31.2	52.3	33.8	28.9	41.6	35.9	34.1
1968, Dec.	35.5	36.8	32.9	55.6	34.5	30.7	44.0	37.7	35.7
1969, Dec.	37.7	39.4	35.0	58.5	36.3	32.6	46.2	39.8	37.9
1970, Dec.	39.8	40.3	37.5	60.8	36.9	35.0	48.8	41.9	40.0
1971, Dec.	41.1	42.0	38.7	62.1	39.4	36.6	50.6	43.7	41.3
1972, Dec.	42.5	43.9	40.1	63.7	40.4	37.8	51.9	45.3	42.7
1973, Dec.	46.2	52.0	42.8	66.5	42.2	39.8	53.7	47.5	46.5
1974, Dec.	51.9	58.3	48.6	72.3	47.7	44.8	58.7	52.4	52.2
1975, Dec.	56.5	61.9	52.3	74.0	52.4	49.2	63.2	55.3	55.8
1976, Dec.	58.2	62.4	56.1	77.4	57.0	54.1	66.5	58.6	58.5
1977, Dec.	62.1	67.1	59.2	80.7	58.5	58.9	69.6	62.3	62.5
1978, Dec.	67.7	74.9	65.1	83.2	64.1	64.1	73.6	66.3	68.1
1979, Dec.	76.7	82.4	75.0	87.8	75.8	70.6	78.7	71.5	77.2
1980, Dec.	86.3	90.7	86.3	93.8	86.9	77.8	86.3	78.7	86.8
1981, Dec.	94.0	94.6	94.0	97.1	96.4	87.3	92.5	86.5	94.4
1982, Dec.	97.6	97.6	97.4	96.7	96.1	96.9	97.7	97.0	96.0
1983, Dec.	101.3	100.2	100.8	101.6	101.9	103.1	101.6	104.7	101.2
1984, Dec.	105.3	104.0	106.1	103.6	106.1	108.4	106.9	111.0	104.8
1985, Dec.	109.3	108.9	109.8	106.5	107.8	116.8	109.2	118.0	108.8
1986, Dec.	110.5	110.9	111.5	107.5	101.4	125.8	112.9	124.5	109.3
1987, Dec.	115.4	114.6	115.6	112.7	107.6	133.1	117.4	132.1	114.2
1988, Dec.	120.5	120.6	120.2	118.0	110.8	142.3	122.8	141.3	119.2

See footnotes at end of table.

ATTACHMENT A – 3b

Table 3. Historical Consumer Price Index for All Urban Consumers (CPI-U) and Urban Wage Earners and Clerical Workers (CPI-W): U.S. city average, major groups—Continued

Year and month	CPI-U								CPI-W
	All items	Food and beverages	Housing	Apparel and upkeep	Transportation	Medical care	Entertainment	Other goods and services	All items
	Indexes 1982-84 = 100, seasonally adjusted except All items								
1987, Jan.	111.2	111.9	112.2	107.3	102.8	126.8	113.3	125.5	110.0
1987, Feb.	111.6	112.0	112.7	107.9	103.4	127.3	113.5	126.4	110.5
1987, Mar.	112.1	112.3	113.0	108.6	104.0	127.8	113.9	126.9	111.0
1987, Apr.	112.7	112.7	113.4	111.0	104.8	128.6	114.5	127.5	111.6
1987, May	113.1	113.2	113.7	111.4	104.8	129.3	114.8	128.1	111.9
1987, Jun.	113.5	113.8	114.0	110.8	106.3	130.0	114.9	128.7	112.4
1987, Jul.	113.8	113.8	114.2	109.9	106.9	130.7	115.4	129.8	112.7
1987, Aug.	114.4	113.9	114.8	110.3	108.7	131.3	115.6	130.7	113.3
1987, Sep.	115.0	114.4	115.0	111.3	108.8	131.9	116.1	129.9	113.8
1987, Oct.	115.3	114.6	115.3	112.7	107.2	132.4	116.9	130.7	114.1
1987, Nov.	115.4	114.7	115.5	113.1	107.7	133.0	117.3	131.3	114.3
1987, Dec.	115.4	115.2	115.9	112.2	107.4	133.5	117.4	131.9	114.2
1988, Jan.	115.7	115.5	116.4	112.3	107.3	134.6	118.1	133.4	114.5
1988, Feb.	116.0	115.3	116.8	112.0	107.1	135.4	118.3	134.5	114.7
1988, Mar.	116.5	115.8	117.2	114.2	107.2	136.0	119.0	135.3	115.1
1988, Apr.	117.1	116.5	117.5	116.5	107.5	136.6	119.6	135.7	115.7
1988, May	117.5	117.0	117.8	116.5	108.2	137.7	119.7	136.4	116.2
1988, Jun.	118.0	117.7	118.2	116.1	108.4	138.3	120.1	137.1	116.7
1988, Jul.	118.5	118.8	118.6	115.4	108.8	138.3	120.5	138.4	117.2
1988, Aug.	119.0	119.4	118.9	113.5	109.8	139.8	120.7	139.9	117.7
1988, Sep.	119.8	120.3	119.2	115.8	109.9	140.7	121.3	139.7	118.5
1988, Oct.	120.2	120.6	119.6	117.9	110.2	141.4	121.8	139.6	118.9
1988, Nov.	120.3	120.8	120.0	117.6	110.5	142.0	122.2	140.3	119.0
1988, Dec.	120.5	121.0	120.5	117.4	110.6	142.7	122.8	141.1	119.2

See footnotes at end of table.

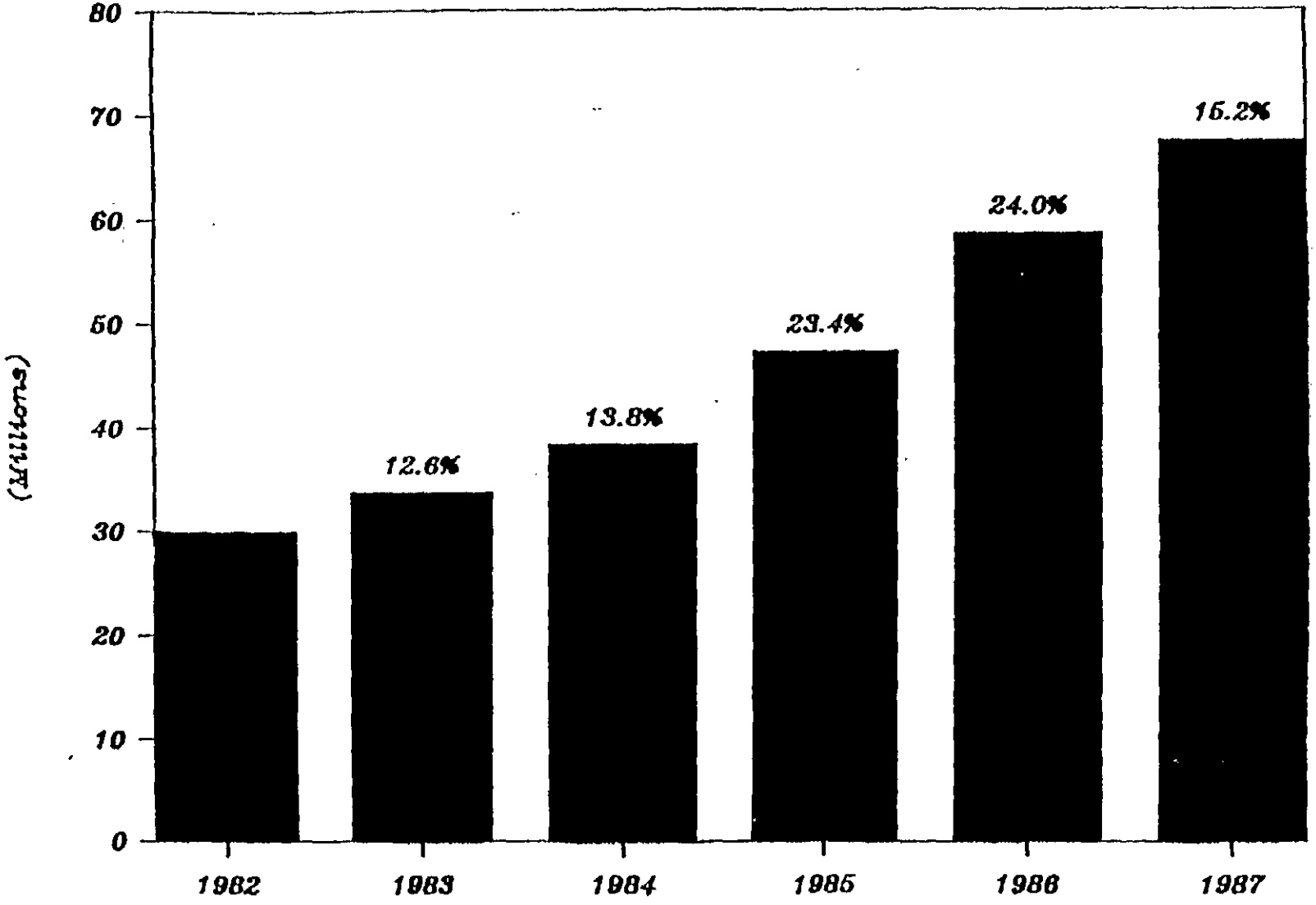
ATTACHMENT A-3c

WEST VIRGINIA MEDICAID CLAIMS RECEIVED

1987 July - December	$130.08 Million
1988 January - June	$143.4 Million
1988 July - December	$150.9 Million
1989 January - June	$170.9 Million

AVERAGE INCREASE OF MEDICAL PAYMENTS

17.8% For Regular Subscribers



ATTACHMENT B-1

The Public Employees Insurance Agency (PEIA) currently contracts with MedCert for utilization review. This service involves preadmission, concurrent, and retrospective reviews, second surgical opinion screening, and catastrophic case management of hospital admissions and/or surgical procedures recommended for State employees and covered dependents. The review determinations are used by the claims administrator in determining if penalties or co-payments for non-notification or failure to comply with standards are to be applied. In addition to the services provided by MedCert, additional cost containment activities are performed by Quality, Inc. This firm performs hospital audits on all bills with ancillary charges in excess of $10,000.

PEIA is considering refinements to the current utilization review system to ensure the quality of health care and further contain costs. One aspect is the new contract with the Preferred Pharmacy Network of West Virginia to review drug coverage, distributing and prescribing practices of pharmacies and doctors. The organization will research whether or not the development of a formulary (written list of drugs that the State will reimburse patients for) is appropriate. Additionally, the network will check therapeutic value of medicines prescribed, and ascertain that physicians and pharmacies aren't providing patients with individual drugs that should not be used together. Utilization of preferred provider organizations (PPO), as reflected in the Omnibus Health Care Act, is being pursued.

HEALTH INSURANCE COVERAGE
BY TYPE OF INSURANCE
Selected States -- Ages 0-64 -- 1986

STATE	TOTAL NUMBER	PERCENT PRIVATE INSURANCE	PERCENT EMPLOYER PROVIDED	PERCENT PUBLIC INSURANCE	PERCENT MEDICAID	PERCENT & NUMBER UNINSURED PERSONS	
United States	199,765,000	73.9%	66.0%	12.0%	8.0%	17.4%	34,759,000
Kentucky	3,001,001	72.3%	62.0%	10.7%	6.7%	21.2%	638,000
Maryland	3,641,000	77.9%	69.8%	10.0%	6.0%	15.0%	546,000
Ohio	9,191,000	76.8%	69.7%	11.3%	8.3%	14.5%	1,332,000
Pennsylvania	9,669,000	79.3%	70.4%	10.9%	8.2%	12.9%	1,245,000
Virginia	4,549,000	76.4%	70.7%	10.0%	5.2%	16.6%	754,000
West Virginia	1,571,000	68.4%	58.3%	17.9%	13.0%	18.6%	292,000

Source: Employee Benefit Research Institute analysis of March, 1986, Current Population Survey

Notes: These data exclude agricultural workers and military personnel. Details may not add because of rounding and duplicate counts.

ATTACHMENT B-2

The Division of Human Services has for many years had basic Medicaid utilization control policies and procedures, with two primary perspectives: program utilization by providers of medical services and utilization by Medicaid eligible recipients. Recent limited fiscal and staff resources have impacted the ability of the Medicaid program to maintain an assertive utilization review service. The program is only minimally meeting federal requirements at present and is rapidly approaching the point where the program will be unable to meet these requirements as well as monitoring mandated State legislation. Inpatient hospital acute care is monitored through a contract with a Professional Review Organization, whose contract is, in turn, monitored by an approved evaluation plan; analysis of system-generated S.U.R. reports and postpatient review of claims history; and claims processing edits which enforce benefit limits. Long term care is monitored through independent professional review and on-site medical review by Medicaid staff; survey and certification by the Division of Health; maintenance of provider agreements; claims processing systems edits and use of system-generated reports. The Quarterly Showing Report certifies to all the above utilization control activities, and is reviewed by the utilization control unit prior to submission to the federal Health Care Financing Administration (HCFA).

Noninstitutional services are monitored through system edits

in support of program coverage limitations; professional medical review for specific health care procedures prior to payment; prior approval for specific services; case planning for durable medical equipment, specialized or high risk services, and out-of-state services other than emergency care. All of these are subject to monitoring by analysis of S.U.R. quarterly reports and postpayment review of claims histories. Provider enrollment procedures constitute another aspect of control which is enforced by requirements that providers be certified, licensed, and duly authorized to practice in their area of service prior to being enrolled.

Recipient utilization control approaches include preventative measures (service limits and certain prior authorization tend to prevent inappropriate utilization) and postpayment utilization review activities. House Bill 4242 formalized in 1988 the drug formulary and utilization control committee, which now meets quarterly. This committee, selected from providers around the State, is responsible for the development of a drug formulary to consist of cost-effective federally approved generic drugs when applicable. A utilization review program is mandated to assure that the prescribing and dispensing of drug products results in the most rational cost-effective medication therapy for Medicaid patients.

Several measures are planned that will emphasize access to care and cost containment. Given the increasing costs of institutional nursing home care, alternatives are being developed to allow recipients the additional choice of community-based

care. Personal care services are now an optional Medicaid service in our State that covers care at home for those who require that level of service. The Medicaid waiver for aged and disabled, which offers service at home to those who are at risk of institutionalization, is planned to expand from the current eighteen counties to statewide. Recent statistics reveal the cost of providing services under the waiver program are only 34% of the average cost of nursing home care. The Division plans to develop exception regulations to preserve the basic agency mission as well as cost containment. Health care services not covered by Medicaid, and thus requiring usage of State dollars only, will be limited to specific exceptions. A total revamp of the Medicaid program is currently under consideration. The measures of increased automating and contracting out selected functions are avenues toward achieving goals of Senate Bill 576. The development of a physician primary care patient management system similar to that in place in Kentucky is anticipated to increase access to care, reduce costs, prevent unnecessary utilization, and reduce inappropriate utilization. This type of system provides more continuity of care, with ultimately, more accessible, appropriate care.

ATTACHMENT B-3

The Division of Health currently maintains a utilization review committee of professional staff that, under agreement with the Medicaid Program, monitors the behavioral health services.

Within the Division of Maternal and Child Health, a monitoring team exists for the sole purpose of performing on-site program evaluations. This includes monitoring for the Pediatric Program, and the Family Planning Program, which utilize fees for service in their programming. The Dental Program performs a divisional review of service reports and of invoices received from the four sites utilizing the dental fee for service schedule.

Contracts or letters of agreement are used in dental, pediatrics, and family planning which detail fees, periodicity schedules for client visits and eligible target population. Policies have been established within the Maternity Program which define the eligibility criteria for Presumptive Coverage payment. Family planning monitors invoices for specific fee usage patterns. Eligibility determination for the MCH programs has been refined so much so that it serves as a built-in monitoring mechanism for those programs.

Future activities may include a contract for utilization review of the Medicaid Case Management Services for the prenatal and infant population to be covered by a proposed Medicaid State Plan Amendment.

Historically, the Workers' Compensation Fund has not experienced difficulties in access to care for injured employees. However, there have been issues of medical care and cost containment confronting the Fund. Inadequate cost containment measures, the lack of a quality assurance program, and the lack of integrated norms of disability and care are concerns.

The Fund currently utilizes a Medical Cost Containment System (MCCS) that was developed and implemented through contract with an independent firm. The MCCS system includes both a fee schedule and utilization review criteria. The Fund also contracts with a vendor for a data base related to pharmaceuticals and amounts paid by the Fund. The MCCS operates on a computerized scanning of invoices. If information provided fails to meet the criteria behind any particular screen, the discrepancy is flagged for manual review. The shortcoming of the system is that screens merely highlight a problem. The manual check is performed by personnel not medically trained and, therefore, not prepared to discuss the need for or cost of a service with a health professional. The same situation exists with the prior authorization process for all hospital admissions and surgeries except for emergencies. In the near future, the current utilization review system is planned to be refined to remedy current impediments.

The Coal Workers' Pneumoconiosis Fund (CWPF) has not utilized a cost containment or utilization review system.

Discussions have been initiated within the Fund for the CWPF to use the Fund's existing MCCS.

The Fund will continue the pharmacy program, which pays average wholesale prices plus dispensing fee to providers. Refinement of this program will be comparable to activities of PEIA and is planned to involve review of the individual drugs prescribed, instances of double billing, frequency and amount of prescribed medicines, and adverse interactions. The Fund is, further, exploring the advisability of purchasing some types of durable medical equipment, rather than renting or leasing. Certain items could be used by different claimants when the useful life of the item exceeds the period of usage by an individual claimant.

The Division of Rehabilitation Services (DRS) currently utilizes preauthorization for medical services, along with adherence to an established fee schedule as the primary methods of curtailing health care expenditures. Periodic revisions are made in an attempt to maintain a current fee schedule.

The methodology by which fees are established varies depending upon the service area; for example: (1) Unit Value System is utilized for physician services, including surgical, radiological, lab, and outpatient diagnostic procedures. These unit value based fees are fairly consistent with Workers' Compensation reimbursement levels; (2) for hospitalization, DRS reimbursement adheres to the interim percentages established and used by Medicaid; (3) orthotics and prosthetics reimbursement is based on fees established by the Medicare Program. For new or uncommonly performed medical procedures for which there is no established unit value, or existing fees are dramatically inconsistent with going rates, DRS establishes fees close to 80% of the prevailing usual and customary charges. This measure increases access to needed health care for rehabilitation clients.

Another cost containment measure is supported in the requirement in federal law that DRS establish a method of selecting those groups of eligible applicants who will be served in order of priority. The agency has established policy in order of selection, or certain categories of clients for whom services

may be prioritized in the event of fiscal limitations. The following are in order of priority: (1) Eligible applicants with severe disabilities; (2) eligible public safety officers with non-severe disabilities whose handicap to employment arose directly from disability sustained in the line of duty; (3) eligible applicants with non-severe disabilities which result in permanent functional limitations; (4) eligible applicants with non-severe disabilities which do not result in permanent functional limitations who require vocational rehabilitation services to obtain or retain competitive employment; (5) eligible applicants with non-severe disabilities which do not result in permanent functional limitations who require vocational rehabilitation services to obtain or retain competitive employment.

The Division plans to participate in the joint access to care and cost containment activities of the interagency health care committee, insofar as possible. Ongoing review and update of fee schedules will continue, as well as the policy of pre-authorization for services. As medical costs are reasonably contained, the DRS anticipates the ability to serve additional clients utilizing the order of priority procedures.

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.

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Interagency Committee on Medical Claims Processing

The Division of Human Services, the Public Employees Insurance Agency, the Division of Health, the Workers' Compensation Fund, and the Division of Rehabilitation Services all process medical fee bills. Currently, each agency administers its own program for the processing of these claims. Some agencies perform all functions internally; others contract with outside vendors to perform part or all of the functions related to payment of these bills.

Under Senate Bill 576, the Omnibus Health Care Act, these agencies are charged with coordination of health-related services in order to achieve more efficient, more cost-effective, and higher-quality services. To that end, the agencies have established the Interagency Committee on Medical Claims Processing, with representatives from each of these agencies, to review the claims processing procedures currently in place and to make recommendations regarding the possible areas for coordination of work. It is the goal of the agencies to achieve full integration of this function to the extent possible.

The Interagency Committee is specifically charged with the following:

1) Review and compare the current processing of medical fee bills by each agency. This review should include all of the following:

— mechanism for receipt of bills, through mail or electronic transfer

— keypunching functions

— mechanism for payment of undisputed bills

— basis upon which decisions are made to "pend" claims

— how pended claims are reviewed; the reasons bills are pended; the exact nature of the review process

— how disputed bills are paid

— mechanism for review of pended bills, including any hearing or other process available to either providers or beneficiaries when bills are denied

2) Analyze the current utilization review, precertification procedures and other cost containment measures used by each agency and achieve the following:

— provide a summary, by agency, of the current practices;

— determine whether the Utilization Review/precertification procedures used by each agency are applicable to the programs of the other agencies and whether these procedures could be used by other agencies;

— determine whether the Utilization Review/precertification procedures used are accomplishing the cost containment goals of the agency;

— determine whether the Utilization Review/precertification procedures currently in use are consistent with the proposals of the Utilization Management Committee, which are currently in draft form.

(3) Analyze the areas of medical bill processing which are amenable to a centralized, or a coordinated, approach;

(4) Analyze the elements of medical fee bill processing which are agency-specific to determine whether the processing can be combined functionally, despite the differences among the agencies. For example, a medical fee bill for Workers' Compensation must be related to the compensable injury. This requires review of the nature of the injury for which disability benefits are being, or have been, paid. This may not, however, necessarily mean that this function cannot be performed through a central claims processing unit. The issue of whether it can be centralized will, however, need to be addressed separately.

(5) Develop a plan for combining medical fee bill processing functions, including consolidated utilization review and precertification procedures.

The committee shall report to the Interagency Health Group every other week with regard to its progress on the above charge. At its first meeting, the committee shall establish a time line for completion of its tasks and report on this time line to the Interagency Health Group. The Division of Health's designee to the committee shall act as chairperson and reporter to the Interagency Health Group.

It is understood that medical cost containment is of utmost importance to the agencies affected by the Omnibus Health Care Act and that coordination of medical fee bill processing is an essential element of cost containment. Therefore, the committee shall proceed with the utmost speed to develop its analysis and plan.

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8/89

WEST VIRGINIA PROCEDURAL RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

TITLE 69

SERIES 1

TITLE: Rules For Hearings Under The Administrative Procedures Act.

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§69-1-1. General

1.1 Scope - This procedural rule is intended to set forth the procedures for administrative hearings which are conducted by the Secretary of the Department of Health and Human Services pursuant to the West Virginia Administrative Procedures Act, West Virginia Code, §29A-5-1 et seq.

1.2 Authority - West Virginia Code, §5F-2-2 and §29A-5-1 et. seq.

1.3 Filing Date - , 1989.

1.4 Effective Date - . 1989.

§69-1-2. Definitions

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

2.2 The term "Act" means the specific statute under which a hearing arises and which statute is among the various statutes for which the Secretary of the Department of Health and Human Resources has administrative responsibility under the provisions of West Virginia Code, §5F-2-1(d).

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 "this rule" means the present procedural rule which is designated in the caption hereof as Title 69, Series 3.

2.5 The term "Secretary" means the Secretary of the Department of Health and Human Resources as provided for by West Virginia Code, §5F-1-1 (1989).

§69-1-3. Administrative Hearings; Notice; and Place.

3.1 All administrative hearings conducted pursuant to this rule will be held in accordance with the provisions of West Virginia Code, §29A-5-1 et seq., and with the provisions of this rule. In any particular case, any special conditions which are set forth in the Act or in other rules promulgated by the Secretary and which are applicable to that case will be adhered to during administrative hearings in lieu of any contrary provision in this rule.

3.2 Unless waived by all the parties to the hearing and by the Secretary, all hearings shall be preceded by at least ten (10) days written notice. The notice shall be given either by personal delivery thereof to the person or to the entity to be notified or by depositing such notice in the certified United States mail, postage prepaid, return receipt requested, in an envelope addressed to such person or other entity at the last known address of such person or other entity. Proof of the giving of notice in either such manner may be made by the affidavit of any officer or assistant or employee of the Secretary, or by affidavit of any person over eighteen years of age, naming the person or other entity to which or to whom such notice was given and specifying the time, place and manner of the giving thereof. If certified mail is used, then a copy of the return receipt shall be attached to the proof of notice.

3.3 Notice of the hearing and service of any document or order shall be upon the parties of record except that any party who is represented by an attorney shall be deemed to have designated that attorney as the proper recipient of all such notices, documents, or orders and service upon that attorney will be the equivalent for all purposes as service upon the party. Notice shall be complete if the written notice is personally tendered to the intended recipient and is either accepted or refused by that recipient. Similarly, notice shall be complete if the written notice is sent by certified mail, return receipt requested, to the recipient and the return receipt shows that it was either accepted by a person at the last known address or was refused by a person at the last known address.

3.4 In any instance where any form of notice, including one arising under subsection 3.2 of this rule or one contained in any order or document, the time period will begin to elapse with the first day following the date of the notice, order, or document. This rule is applicable whether the notice is delivered personally or served by mail.

3.5 The subsection 3.2 notice shall contain the date, time, and place of the hearing and a short and plain statement of the matters asserted. If the Secretary is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon application by a party a more definitive and detailed statement shall be furnished.

3.6 The hearing shall be held in the county selected by the Secretary.

§69-1-4. Parties and Conduct of Hearings

4.1 At the hearing, an opportunity shall be afforded all parties to present evidence and argument with respect to the matters and issues involved. Any person interested in the proceeding, but not a party thereto, shall be permitted to testify as to the issues in controversy after first being placed under oath or affirmation. Any such interested person, who is not a party, shall not, however, be permitted to submit argument or to cross-examine other witnesses. Argument may be restricted to a presentation in written form. All of the testimony and evidence at the hearing shall be reported by stenographic notes and characters or by mechanical means. All rulings on the admissibility of testimony and evidence shall also be reported. The Secretary shall prepare an official record, which shall include reported testimony and exhibits in each contested case, and all agency staff memoranda and data used in consideration of the case, but it shall not be necessary to transcribe the reported testimony unless required for purposes of rehearing or judicial review. Upon request from any party to the hearing, all reported testimony and evidence at a hearing shall be transcribed, and a copy thereof furnished to the party at its expense. The Secretary shall have the responsibility for making arrangements for

the transcription of the reported testimony and evidence and such transcription shall be accomplished with all dispatch.

4.2 Evidentiary depositions may be taken and read as in civil actions in the circuit court of this state.

4.3 Except to the extent required by statute or by this rule, all hearings under this rule will be conducted in accordance with the then current versions of the "Rules of Civil Procedure for Trial Courts of Record," "Trial Court Rules for Trial Courts of Record," and "Local Rules for Kanawha County Civil Courts" as those rules would apply to a trial court sitting without a jury.

4.4 All hearings shall be conducted in an impartial manner and shall be open to members of the public. The Secretary and every Hearing Officer appointed by the Secretary shall have the power to administer oaths and affirmations, certify official acts, take depositions, rule upon offers of proof and receive relevant evidence, regulate the course of the hearing, hold conferences for the settlement or simplification of the issues by consent of the parties, dispose of procedural requests, motions, or similar matters, and take such other actions as are authorized by this rule.

4.5 During a hearing, irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The then current "Rules of Evidence" as applied in civil cases by a court sitting without a jury shall be followed. However, when necessary to ascertain facts not reasonably susceptible of proof under those rules, evidence not admissible thereunder may be admitted, except where precluded by statute, if it is of a type commonly relied upon by reasonably prudent persons in the conduct of their office. The Hearing Officer shall be bound by the rules of privilege recognized by law. Objections to evidentiary offers shall be noted in the record, but exceptions to rulings by the Hearing Officer shall not be made. Any party to any hearing may vouch the record as to any excluded

testimony or other evidence provided that the Hearing Officer may elect to require that the excluded testimony be submitted in written form following the hearing.

4.6 All evidence, including papers, records, agency staff memoranda and documents in the possession of the Secretary, of which he or she desires to avail himself or herself, shall be offered and made a part of the record in the case, and no other factual information or evidence shall be considered in the determination of the case. Documentary evidence may be received in the form of copies of excerpts or by incorporation by reference. In all cases, copies of orders, proceedings, or records in the office of the Secretary shall be equal to the original in evidence.

4.7 Every party as well as the Secretary and his or her staff shall have the right of cross-examination of witnesses who testify, and shall have the right to submit rebuttal evidence.

4.8 All witnesses who testify during a hearing shall first be subject to oath or affirmation and any testimony submitted by deposition shall show on the face thereof that the witness was so qualified.

4.9 The Hearing Officer may take notice of judicially cognizable facts. All parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material so noticed, and they shall be afforded an opportunity to contest the facts so noticed.

§69-1-5. Correction of the Record

Upon motion in writing served by any party or by the Secretary as notice may be served pursuant to subsection 3.2 of this rule and therein assigning error or omission in any part of any transcript of

the proceedings had and testimony taken at any such hearing, the Hearing Officer shall settle all differences arising as to whether such transcript truly discloses what occurred at the hearing or shall direct that the transcript be corrected and revised in the respects designated by the Hearing Officer, so as to make it conform to the whole truth.

§69-1-6. Subpoenas

6.1 The Secretary may issue subpoenas and compel the attendance of witnesses and the production of pertinent books, accounts, papers, records, documents, and testimony. All subpoenas and subpoenas duces tecum shall be issued in the name of the Secretary, but any party requesting their issuance must see that they are properly served. Service of subpoenas duces tecum issued at the instance of the Secretary shall be the responsibility of the Secretary. All requests by interested parties for subpoenas and subpoenas duces tecum shall be in writing and shall contain a statement acknowledging that the requesting party agrees to pay service fees and fees for the attendance and travel of witnesses.

6.2 Every subpoena or subpoena duces tecum shall be served at least five (5) days before the return date thereof, either by personal service made by any person over eighteen years of age or by registered or certified mail. But a return acknowledgment signed by the person to whom the subpoena or subpoena duces tecum is directed shall be required to prove service by registered or certified mail. If service is by mail, then the five (5) day notice period shall not begin to run until the date the subpoena or subpoena duces tecum is received by the person or entity subject thereto as shown by the date on the return receipt.

6.3 Any person who serves any such subpoena or subpoena duces tecum shall be entitled to the same fee as sheriffs who serve

witness subpoenas for the circuit courts of this state. Fees for the attendance and travel of witnesses shall be the same as for witnesses before the circuit courts of this State. All such fees shall be paid by the Secretary if the subpoena or subpoena duces tecum was issued, without the request of an interested party, at the instance of the Secretary. All such fees related to any subpoena or subpoena duces tecum issued at the instance of an interested party shall be paid by the party who asks that such subpoena or subpoena duces tecum be issued.

6.4 Upon motion made promptly and in any event before the time specified in a subpoena duces tecum for compliance therewith, the circuit court of the county in which the hearing is to be held, or the circuit court in which the subpoena duces tecum was served, or the judge of either such court in vacation, may grant any relief with respect to such subpoena duces tecum which either such court, under the West Virginia Rules of Civil Procedure for Trial Courts of Record, could grant, and for any of the same reasons, with respect to a subpoena duces tecum issued from either such court.

6.5 In case of disobedience or neglect of any subpoena or subpoena duces tecum served on any person, or the refusal of any witness to testify to any matter regarding which he or she may be lawfully interrogated, the circuit court of the county in which the hearing is being held, or the judge thereof in vacation, upon application by the Secretary, shall compel obedience by attachment proceedings for contempt of a subpoena or subpoena duces tecum issued from such circuit court or a refusal to testify therein.

6.6 The issuance of a subpoena duces tecum will be refused only in an instance when there is good reason to believe that the subpoena power is being abused. All subpoenas and subpoenas duces tecum will state on their face the name of the party who requested it.

§69-1-7. Discovery

Discovery shall be engaged in only with the consent of the Hearing Officer or, if a Hearing Officer has not yet been assigned, with the consent of the Secretary. All discovery requests will be submitted to the appropriate official at the same time as the discovery request is served upon the other party. If the official determines that the requested information is relevant and material to the issues to be heard and not unduly burdensome, the official will permit the discovery and set a reasonable time frame for the disclosure of the information. Determination of a reasonable time frame will be premised upon the nature and scope of the information requested and the date on which the hearing is scheduled. The official shall attempt to avoid continuing a previously scheduled hearing.

§69-1-8. Hearing Officers

8.1 Every Hearing Officer appointed by the Secretary to conduct a hearing under this rule shall be an attorney licensed to practice law in this State.

8.2 The Hearing Officer is authorized to receive and rule upon any procedural matter arising before, during, or after a hearing. All final rulings on substantive matters shall be made by the Secretary.

8.3 The Hearing Officer shall continue a hearing upon motion of the Secretary. Requests for continuances by a party shall not be granted as a matter of course, but only upon a showing of good cause which cause shall be strictly construed against the requests.

§69-1-9. Concluding The Hearing

9.1 At the conclusion of the hearing, the parties shall be permitted to file proposed findings of fact, conclusions of law, and such legal briefs or memoranda as they wish. The parties shall be permitted seven (7) days to file such items which filings shall be concurrent. The parties shall be permitted three (3) days to respond to the filing of any other party. No further argument shall be permitted.

9.2 Thereafter, unless the Secretary served as the Hearing Officer in the particular case, the Hearing Officer will prepare a report and recommendation which shall contain proposed findings of fact and conclusions of law as suggested by the Hearing Officer for the Secretary's approval. The parties to the hearing shall then be permitted seven (7) days in which to file objections or comments upon the report and recommendation and three (3) more days to respond to each others' objections or comments. Thereafter, the Secretary shall decide whether to accept the report and recommendation, to reject it, to modify it, or to remand the matter to the Hearing Officer for further proceedings or upon other instructions. The Secretary retains his or her right to review any and all proposed findings of facts against the record and to disagree therewith provided that the Secretary states the basis for the disagreement in his or her final order. The Secretary shall render either a final order or an interlocutory order as his or her decision may require in which the Secretary accepts in whole or in part the proposed findings of fact and conclusions of law submitted by the Hearing Officer and, to the extent that the Secretary rejects or modifies the report and recommendation of the Hearing Officer, the Secretary shall furnish his or her own findings of fact and conclusions of law. If in a particular case the Secretary personally served as the Hearing Officer, the Secretary shall issue a decision following his or her review of the proposed findings of fact, conclusions of law, and legal briefs or memoranda.

9.3 A copy of the final order or decision of the Secretary shall be served upon each party and the party's attorney of record, if any, either in person or by certified mail.

9.4 All appeals from the final order or decision of the Secretary shall be taken pursuant to West Virginia Code, §29A-5-4.

§69-1-10. 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 affect without the invalid provisions or application and to this end the provisions of this rule are declared to be severable.

WEST VIRGINIA PROCEDURAL RULE

DEPARTMENT OF HEALTH AND HUMAN RESOURCES

TITLE 69

SERIES 3

TITLE: Rules For Hearings Under The Administrative Procedures Act.

TABLE OF CONTENTS

SECTION		PAGE
§69-1-1.	General	1
§69-1-2.	Definitions	2
§69-1-3.	Administrative Hearings; Notice; and Place	2
§69-1-4.	Parties and Conduct of Hearings	4
§69-1-5.	Correction of the Record	6
§69-1-6.	Subpoenas	7
§69-1-7.	Discovery	9

TABLE OF CONTENTS - CONTINUED

SECTION		PAGE
§69-1-8.	Hearing Officers	9
§69-1-9.	Concluding The Hearing	10
§69-1-10.	Severability	11