WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #2

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2004 JUL 23 P 4:36

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Department of Health and Human Resources TITLE NUMBER: 69CSR2

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

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 2

TITLE OF RULE BEING AMENDED: Implementation of the Omnibus Health Care Act

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON August 23, 2004 AT 4:00 p.m. ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS:

John Law, Assistant Secretary
Department of Health and Human
Resources, Office of Communications
and Legislative Affairs
State Capitol Complex, Bldg. 3
Room 206
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Authorized Signature

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

$8.00

Approval of Filing

I, Paul L. Nusbaum, Secretary of the Department of Health and Human Resources, do approve and consent to the filing of an amendment to existing Legislative Rule 69CSR2, Implementation of the Omnibus Health Care Act this 23rd day of July 2004.

Signed: _____

Paul L. Nusbaum,
Secretary, Department of
Health and Human Resources

Brief Summary of Proposed Rule (Amendment)

The Omnibus Health Care Act (the Act) was enacted in 1989 and, inter alia, required the Department of Health and Human Resources (DHHR) to promulgate Legislative Rules to implement the provisions of the Act. DHHR promulgated such rules in 1990 in three separate series, namely 69CSR2, 69CSR3, and 69CSR4. The Act, as passed in 1989, contained provisions which set forth procedures: 1. for health care providers to "withdraw" from the mandates of the Act; and, 2. a specific health care claim reimbursement calculation methodology (see attached copies of former legislation.). Consequently, Series 2 (69CSR2) and Series 3 (69CSR3) of the Rules, as promulgated in 1990, contained substantial portions which set out the "withdrawn provider" and "payment calculations" procedures.

The present proposed amendment to these rules (69CSR2 and 3) is necessary, because the Legislature in 1991 eliminated the language in the Act permitting withdrawal of providers and requiring the specific payment methodology (see attached copies of former legislation with deleted language marked). The present proposed amendment to the Rule(s) brings Series 2 and 3 into compliance with existing law (W.Va. Code§§16-29D-1 et. seq.) by eliminating the "withdrawn provider" and "health care claim reimbursement calculation" language from the Rule(s) (69CSD2 and 3).

BKH:jh
Y:\2004 Work Folder\Huffman, Keith\Brief Summary of Proposed Rule 72304.doc

Statement of Circumstances

The Legislature, in 1991, substantially amended the enabling legislation for these Rules (W.Va. Code §16-29D-1 et. seq., the Omnibus Health Care Act). These 1991 amendments eliminated significant sections of the Omnibus Health Care Act (Act) relating to: 1. the ability of health care providers to elect to withdraw from the mandates of the Act; and 2. the specific way certain health care claim reimbursements must be calculated. The existing rule still contains major portions which set out the withdrawn provider and health care claim reimbursement calculation methodology. The rule needs amended to eliminate these provisions which no longer have statutory authority to support them.

BKH:tr

L:\Keith Huffman\statement of circumstances july 23 2004.doc

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Implementation of the Omnibus Health Care Act

Type of Rule: X Legislative ____ Interpretive ____ Procedural

Agency: Department of Health and Human Resources

Address: John Law, Assistant Secretary, Department of Health and Human Resources Office of Communications and Legislative Affairs
State Capitol Complex

Building 3, Room 206

1900 Kanawha Boulevard, East 558-7899 phone Fax 558-7075
Charleston, West Virginia 25305

1. Effect of Proposed rule:

	ANNUAL		FISCAL YEAR		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	NA	N/A	N/A	N/A	N/A
PERSONAL SERVICES	N/A	N/A	N/A	N/A	N/A
CURRENT EXPENSE	N/A	N/A	N/A	N/A	N/A
REPAIRS & ALTERATIONS	N/A	N/A	N/A	N/A	N/A
EQUIPMENT	N/A	N/A	N/A	N/A	N/A
OTHER	N/A	N/A	N/A	N/A	N/A

2. Explanation of Above Estimates:
The amendment of the Rule will have no fiscal impact.

3. Objectives of These Rules:
To bring the Rule into compliance with amendments to the Omnibus Health Care Act (W.Va. Code Section 16-29D - 1 et seq), which occurred after the initial promulgation of the Rule.

Rule Title: Implementation of the Omnibus Health Care Act

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:

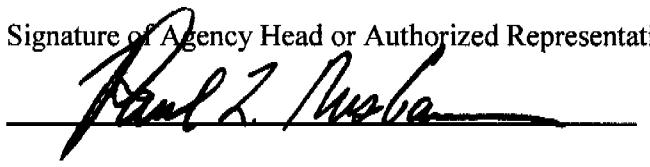
      None

   C. Economic Impact on Citizens/Public at Large.

      None

Date: July 23, 2004

Signature of Agency Head or Authorized Representative:



TITLE 69
LEGISLATIVE RULE
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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2004 JUL 23 P 4:37
OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

SERIES 2
IMPLEMENTATION OF OMNIBUS HEALTH CARE ACT

§69-2-1. General.

1.1. Scope. -- This 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 Human Services, 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. -- W.Va. Code §16-29D-7.

1.3. Filing Date. --

1.4. Effective Date. --

§69-2-2. Definitions.

2.1. As used in this 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 West Virginia Code §16-29D-1 et seq., 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" includes 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 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.

4.1. 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.~~ Emergency Services

~~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 also agrees 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 beneficiaries who request services or refuses to deliver services only for reasons not related to such persons' status as beneficiaries under a particular state program 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 beneficiaries who request obstetric services, or to at least a sufficient number of 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 shall 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 shall not discriminate in accepting patients in favor of beneficiaries of another state's medicaid program and against beneficiaries of this state's medicaid program because of differing rates of reimbursement.~~

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

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

~~5.4.~~ 5.1 The ~~implied~~ agreement as a matter of law of ~~set forth in subsection 5.2 of this rule~~ a health care provider to accept assignment of benefits of a state program beneficiary pursuant to the Act shall not arise ~~in the following circumstances. 5.4.1. When~~ 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: Provided, that 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 as a matter of law. ~~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~~

that the immediate threat of death or permanent harm has been resolved to the extent that the patient is stable and/or capable of being safely transported.

~~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-section 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 by a physician of a state program beneficiary who comes to the emergency room and the provision of all necessary follow-up services will not obligate that physician to deliver health care services to other state program beneficiaries. But, if the physician elects to treat that beneficiary for unrelated conditions in the physician's private office, then the implied agreement to treat other state program beneficiaries will arise at the time the unrelated treatment is provided.~~

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

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

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

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

6.2. As a general rule, the health care provider shall have forty-five (45) days from the effective date of the provider's withdrawal within which to cease continued treatment of the provider's patients who are state program beneficiaries. Not later than ten (10) days after the effective date of withdrawal, the withdrawing provider shall give his, her or its state program beneficiary patients who are under active treatment written notice of such provider's withdrawal, to enable these patients to arrange for care by other providers. Failure by the provider to deliver the notice to a patient within the ten (10) day period shall render the provider's charge for any health care services delivered beyond the forty-five (45) day period null and void and it shall not be recoverable from either the beneficiary or the state division or department. Exceptions to this general rule are stated below. During the forty-five (45) day period, the health care provider may continue to provide health care services to state program beneficiaries who were patients of the provider prior to the effective date of the provider's withdrawal. With the exceptions noted in subsection 5.4 of this rule, 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 state in subsection 6.2 of this rule, the health care provider may elect to continue to treat individuals state program beneficiaries who he, she or it is treating as of the effective date of the withdrawal in the following specific categories without obligating the provider to undertake the delivery of health care services to state program beneficiaries. However, nothing in this subsection shall permit the health care provider to continue to provide health care services beyond the forty-five (45) day period described in subsections 6.1 and 6.2 to previously established state program beneficiaries who do not come within the following specific categories of patients or permit the provider to accept new state program beneficiaries as patients after the effective date of his, her or its withdrawal. The purpose of these exceptions is to ensure the continued access by state program beneficiaries to quality health care services in these special situations.

6.3.1. A withdrawing health care provider may continue to treat 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 withdrawing health care provider may continue to treat 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, claim number in the case of a beneficiary of the Division of Workers' Compensation. 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 withdrawing health care provider may continue to treat 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 other 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 other 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. A withdrawing health care provider may continue to treat 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 considered to be in violation of the Act 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 or 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, §29-5-1 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 the 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 comply, or refuses to state clearly its position, then the Secretary or his or her designee may consider 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~~. 6. Testimony by Providers.

~~7.1.~~ 6.1. Nothing in this rule or in the Act prohibits 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 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~~ 7. Violations and Show Cause Proceedings; Penalties.

~~8.1.~~ 7.1. 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 as provided by the Act and may order that the health care provider by removed from any list of approved providers for whose services a department or division may pay in the future.

~~8.2.~~ 7.2. 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 of a hearing at which such health care provider or other legal entity shall appear to show cause why a civil penalty or removal from any list, or both, should not be imposed. Nothing in this rule shall limit the Secretary's authority to resolve informally any alleged violation, by such means as stipulation, agreed settlement, consent order, default, or other appropriate action.

~~8.2.1. For the purposes determining whether or not a violation of section 5 of this rule has occurred, 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 reports by others that a person was denied health care services is not a basis for a finding of probable cause, unless other corroborative evidence is received.~~

~~8.3~~ 7.3 At the hearing, the Secretary shall arrange to have the evidence in support of the allegations presented and shall afford the health care provider or other legal entity an opportunity to cross-examine the state's witnesses and shall afford the health care provider or other legal entity an opportunity to present testimony and enter evidence in support of its position. The State shall bear the burden of proving a violation of the Act.

~~8.4.~~ 7.4. 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.

~~8.5.~~ 7.5. If, after reviewing the record of such hearing, the Secretary determines, by a preponderance of the evidence, that such health care provider is in violation of the Act, of this rule, or any other rule promulgated under the Act, or any plan, order or directive issued under the Act or such rule, the Secretary may assess a civil penalty as provided by the Act and may remove a health care provider from any list of approved providers for whose services a department of division may pay in the future. In exercising his or her discretion in fixing the amount of the penalty as well as determining whether to remove a health care provider from a list, the Secretary shall take into account 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 be relevant to a particular case.

~~8.6.~~ 7.6. Any health care provider or other legal entity proceeded against under this section ~~8~~ 7 shall receive notice in writing by certified mail of the Secretary's 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 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: Provided, that 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.

~~8.7.~~ 7.7. 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 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 from a department's or division's approved provider list. 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: Provided, that such hearing may not be conducted on an ex parte basis.

~~8.8.~~ 7.8. If the health care provider or other legal entity penalized or ordered removed from a department's or division's approved provider list either loses an appeal or does not appeal 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.

~~8.9~~ 7.9. 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.

~~8.10.~~ 7.10. Any health care provider removed from a department's or division's approved provider list pursuant to this section ~~8~~ 7 may petition the Secretary for reinstatement to such list after one-hundred and eighty (180) days from his removal. Any appeal by the provider of the Secretary's decision shall be taken and handled in accordance with West Virginia Code, §29A-5-4.

~~8.11.~~ 7.11. Any patient-identifying information or records obtained by the Secretary or his or her employees or agents, or by any other department or division subject to the Act, during any investigation or enforcement of the Act, this rule, or any other rule duly promulgated by the Secretary under the provisions of the Act, shall be kept confidential and, shall not be released to the public, and shall be treated in accordance with all applicable privacy laws. ~~If the Secretary receives allegations that a provider is not in compliance with subsection 5.2 of this rule, then before the Secretary may subpoena patient-identifying records or information, the Secretary shall first afford the provider an opportunity to submit a verified statement from the provider's office manager, accountant or other similar person, attesting to: (1) the total number of state medicaid beneficiaries (including patients of other indigent programs recognized pursuant to subsection 5.3.3 of this rule) to which the provider has delivered (or scheduled for) health care services during a time period agreed to by the Secretary; and (2) the total number of patients who are State residents to which the provider has delivered (or scheduled for) health care services during this same period. The statement shall also explain in detail how these patient totals were derived. If the statement indicates that the provider in question has delivered health care services to (or scheduled health care services for) a sufficient number of patients who are state medicaid beneficiaries (including patients of indigent programs recognized pursuant to subsection 5.3.3 of~~

~~this rule) to equate to at least fifteen (15) percent of the total number of patients who are State residents to which the provider has delivered (or scheduled for) health care services during the same period, then the Secretary may not subpoena patient identifying records or information unless the Secretary has reasonable cause to question the accuracy of the statement submitted by the provider or for other reasonable cause. Nothing in this section shall prohibit the Secretary from obtaining at any time patient identifying records or information if the patient has consented to their release.~~

~~§69 2 9~~. § 69-2-8. Declaratory Rulings and Informal Opinions.

~~9.1~~. 8.1. 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~~. §69-2-9. Severability.

~~10.1.~~ 9.1. If any provision of this rule or the application thereof to any entity or circumstance is held invalid, such invalidity does 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 severable.

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ENROLLED

COMMITTEE SUBSTITUTE
FOR

COMMITTEE SUBSTITUTE
FOR

Senate Bill No. 576

(By Senators Tucker, Mr. President, and Harman,
By request of the Executive)

[Passed April 8, 1990; in effect from passage.]

AN ACT to repeal section four, article twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended; to amend and reenact section twenty of said article twenty-nine-b; to further amend chapter sixteen of said code by adding thereto a new article, designated article twenty-nine-d; to amend and reenact section three, article four, chapter twenty-three of said code; and to amend article twelve, chapter twenty-nine of said code by adding thereto a new section, designated section five-c, all relating to the health care cost review authority; repealing a freeze on rates; repealing certain expedited rate review processes; authorizing the creation of other expedited rate review processes; relating to rate determinations; approval of rate increases for hospitals; providing for regulations regarding reporting requirements; providing legislative findings and legislative purposes; providing definitions for certain articles; providing that pharmacies and pharmacists not be considered health care providers under certain circumstances; providing for cooperation among agencies; providing for the development of plans concerning health care by specified department or divisions of state government; providing for reports to the Legislature; prohibitions on balance billing and exceptions and termination thereof; providing exceptions for certain health care providers; providing criteria for an acceptable preferred provider contract; providing for rates of reimbursement and exceptions thereto; exemption from and application of antitrust laws; providing civil penalties for violations of the article and provisions for removal as a provider; providing a severability clause for certain articles; authorizing promulgation of rules by certain departments; providing schedules for maximum disbursements for medical, surgical and hospital treatment for workers' compensation; providing for submission of the rate schedule to the Legislature; requiring verification for workers' compensation payments; prohibiting charges in excess of scheduled amounts; providing for employer participation in preferred provider organizations, programs or cost containment relationships; and penalties for violations of article.

Be it enacted by the Legislature of West Virginia:

That section four, article twenty-nine-b, chapter sixteen of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be repealed; that section twenty of said article twenty-nine-b be amended and reenacted; that said chapter sixteen be further amended by adding thereto a new article, designated article twenty-nine-d; that section three, article four, chapter twenty-three of said code be amended and reenacted; and that article twelve, chapter twenty-nine of said code be amended by adding thereto a new section, designated section five-c, all to read as follows:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 29B. WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY.

§16-29B-20. Rate determination.

(a) Upon commencement of review activities, no rates may be approved by the board nor payment be made for services provided by hospitals under the jurisdiction of the board by any purchaser or third-party payor to or on behalf of any purchaser or class of purchasers unless:

(1) The costs of the hospital's services are reasonably related to the services provided and the rates are reasonably related to the costs;

(2) The rates are equitably established among all purchasers or classes of purchasers within a hospital without discrimination unless federal or state statutes or regulations conflict with this requirement. Equity among classes of purchasers may be achieved by considering demonstrated differences in the financial requirements of hospitals resulting from service, coverage and payment characteristics of a class of purchasers. The provision for differentials in rates among classes of purchasers should be carried out in the context of each hospital's total financial requirements for the efficient provision of necessary services. The board shall institute a study of objective methods of computing the percentage differential to be utilized for all hospitals in determining appropriate projected gross revenues under subsection (b) of this section. Such study shall include a review and determination of the relevant and justifiable economic factors which can be considered in setting such differential. The differential shall be allowed for only those activities and programs which result in quantifiable savings to the hospital with respect to patient care costs, bad debts, free care or working capital, or reductions in the payments of other payors. Each component utilized in determining the differential shall be individually quantified so that the differential shall equal the value assigned to each component. The board shall consider such matters as coverage to individual subscribers, the elderly and small groups, payment practices, savings in hospital administrative costs, cost containment programs and working capital. The study shall also provide for a method of annual recomputation of the differential and triennial recomputation of all other components. The board may contract with any person or entity to assist the board in the discharge of its duties as herein stated. Whoever obstructs any person or entity conducting a study authorized under the provisions of this section shall be deemed to be in violation of this article and shall be subject to any appropriate actions, including injunctive relief, as may be necessary for the enforcement of this section;

(3) The rates of payment for medicaid are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated hospitals subject to the provisions of this article. The rates shall take into account the situation of hospitals which serve disproportionate numbers of low income patients and assure that individuals eligible for medicaid have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality;

(4) The rates are equitable in comparison to prevailing rates for similar services in similar hospitals as determined by the board;

(5) In no event shall a hospital's receipt of emergency disaster funds from the federal government be included in such hospital's gross revenues for either rate-setting or assessment purposes.

(b) In the interest of promoting efficient and appropriate utilization of hospital services the board shall review and make findings on the appropriateness of projected gross revenues for a hospital as such revenues relate to charges for services and anticipated incidence of service. The board shall further render a decision as to the amount of net revenue over expenditures that is appropriate for the effective operation of the hospital.

(c) When applying the criteria set forth above, the board shall consider all relevant factors, including, but not limited to, the following: The economic factors in the hospital's area; the hospital's efforts to share services; the hospital's efforts to employ less costly alternatives for delivering substantially similar services or producing substantially similar or better results in terms of the health status of those served; the efficiency of the hospital as to cost and delivery of health care; the quality of care; occupancy level; a fair return on invested capital, not otherwise compensated for; whether the hospital is operated for profit or not for profit; costs of education; and, income from any investments and assets not associated with patient care, including, but not limited to, parking garages, residences, office buildings, and income from foundations and restricted funds whether or not so associated.

(d) Wages, salaries and benefits paid to or on behalf of nonsupervisory employees of hospitals subject to this article shall not be subject to review unless the board first determines that such wages, salaries and benefits may be unreasonably or uncustomarily high or low. Said exemption does not apply to accounting and reporting requirements contained in this article, nor to any that may be established by the board. "Nonsupervisory personnel," for the purposes of this section, means, but is not limited to, employees of hospitals subject to the provisions of this article who are paid on an hourly basis.

(e) Reimbursement of capital and operating costs for new services and capital projects subject to article two-d of this chapter shall not be allowed by the board if such costs were incurred subsequent to the eighth day of July, one thousand nine hundred seventy-seven, unless they were exempt from review or approved by the state health planning and development agency prior to the first day of July, one thousand nine hundred eighty-four, pursuant to the provisions of article two-d of this chapter.

(f) The board shall consult with relevant licensing agencies and may require them to provide written

findings with regard to their statutory functions and information obtained by them in the pursuit of those functions. Any licensing agency empowered to suggest or mandate changes in buildings or operations of hospitals shall give notice to the board together with any findings.

(g) Rates shall be set by the board in advance of the year during which they apply except for the procedure set forth in subsection (c), section twenty-one of this article and shall not be adjusted for costs actually incurred.

(h) All determinations, orders and decisions of the board with respect to rates and revenues shall be prospective in nature.

(i) No hospital may charge for services at rates in excess of those established in accordance with the requirements of and procedures set forth in this article.

(j) Notwithstanding any other provision of this article, the board shall approve all requests for rate increases by hospitals which are licensed for one hundred beds or less and which are not located in a Standard Metropolitan Statistical Area where the rate of increase in the hospital's gross inpatient revenues per discharge for nonmedicare and nonmedicaid payors is equal to or less than the rate of inflation for the hospital industry nationally as measured by the most recent hospital market basket component of the consumer price index as reported by the United States Bureau of Labor Statistics applicable to the hospital's fiscal year. The board may, by regulation, impose reporting requirements to ensure that a hospital does not exceed the rate of increases permitted herein.

(k) Notwithstanding any other provision of this article, the board shall develop an expedited review process applicable to all hospitals licensed for more than one hundred beds or that are located in a Standard Metropolitan Statistical Area for rate increase requests which may be based upon a recognized inflation index for the national or regional

hospital industry. The board shall adopt emergency regulations implementing this subsection within ninety days after the effective date of this subsection and shall thereafter submit a proposed legislative rule to the Legislature for consideration at its regular session in the year one thousand nine hundred and ninety.

ARTICLE 29D. STATE HEALTH CARE.

§16-29D-1. Legislative findings; legislative purpose.

(a) The Legislature hereby finds as follows:

(1) That a significant and ever-increasing amount of the state's financial resources are required to assure that the citizens of the state who are reliant on the state for the provision of health care services and payment thereof receive such, whether through the public employees insurance agency, the state medicaid program, the workers' compensation fund, the division of rehabilitation services or otherwise;

(2) That the state has been unable to timely pay for such health care services;

(3) That the public employees insurance agency and the state medicaid program face serious financial difficulties in terms of decreasing amounts of available federal or state dollars by which to fund their respective programs and in paying debts presently owed;

(4) That, in order to alleviate such situation and to assure such health care services, in addition to adequate funding of such programs, the state must effect cost savings in the provision of such health care;

(5) That it is in the best interest of the state and the citizens thereof that the various state departments and divisions involved in such provision of health care and the payment thereof cooperate in the effecting of cost savings; and

(6) That the health and well-being of all state citizens, and particularly those whose health care is provided or paid for by the public employees insurance agency, the state medicaid program, the workers' compensation fund and the division of rehabilitation services, are of primary concern to the state.

(b) This article is enacted 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.

§16-29D-2. Definitions.

(a) "Coordination of benefits" means a provision establishing 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.

(b) The term "health care" or "health care services" means 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, chiropractic physicians, 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.

(c) "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

article, pharmacists and pharmacies shall not be considered health care providers.

§16-29D-3. Agencies to cooperate and to provide plan; contents of plan; reports to Legislature; late payments by state agencies and interest thereon.

(a) All departments and divisions of the state, including, but not limited to, the division of employment security, the division of health, the division of human services, and the division of workers' compensation within the department of health and human resources; the public employees insurance agency within the department of administration; the division of rehabilitation services or such other department or division as shall supervise or provide rehabilitation; and the West Virginia board of regents or such other department or division as shall govern the state medical schools, are authorized and directed to cooperate in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of such departments and divisions and to ensure the containment of costs in the payment for such services.

(b) 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 the Legislature that nothing contained in this article 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.

(c) Such departments and divisions shall develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including the public employees insurance agency and the workers' compensation fund, the division of rehabilitation services

and, to the extent permissible, the state medicaid program. The plan or plans may include, among other things, and the departments and divisions are hereby authorized to enter into:

(1) Utilization review and quality assurance programs;

(2) The establishment of a schedule or schedules of the maximum reasonable amounts to be paid to health care providers for the delivery of health care services covered by the plan or plans. Such a schedule or schedules may be either prospective in nature or cost reimbursement in nature, or a mixture of both: *Provided*, That any payment methods or schedules for institutions which provide inpatient care shall be institution-specific and shall, at a minimum, take into account disproportionate share of medicaid, charity care and medical education: *Provided, however*, That in no event may any rate set in this article for an institutional health care provider be greater than such institution's current rate established and approved by the health care cost review authority pursuant to article twenty-nine-b of this chapter;

(3) Provisions for making payments in advance of the receipt of health care services by a beneficiary, or in advance of the receipt of specific charges for such services, or both;

(4) Provisions for the receipt or payment of charges by electronic transfers;

(5) Arrangements, including contracts, with preferred provider organizations; and

(6) Arrangements, including contracts, with particular health care providers to deliver health care services to the beneficiaries of the programs of the departments and divisions at agreed upon rates in exchange for controlled access to the beneficiary populations.

(d) The director of the public employees insurance agency shall contract with an independent actuarial company for a review every four years of the claims

experience of all governmental entities whose employees participate in the public employees insurance agency program, including, but not limited to, all branches of state government, all state departments or agencies (including those receiving funds from the federal government or a federal agency), all county and municipal governments, or any other similar entities for the purpose of determining the cost of providing coverage under the program, including administrative cost, to each such governmental entity.

(e) Except as provided in subsection (h), section three of this article, any health care provider who agrees to deliver health care services to any beneficiary of a health care program of a department or division of the state, including the public employees insurance agency, the state medicaid program, the workers' compensation fund and the division of rehabilitation services, the charges for which shall be paid by or reimbursed by any department or division which participates in a plan or plans as described in this section, shall be deemed to have agreed to provide health care services to the beneficiaries of health care programs of all of the other departments and divisions participating in a plan or plans: *Provided*, That a health care provider shall be in compliance with this subsection if the health care provider actually delivers health care services to all such patients who request such services or if the health care provider actually delivers health care services to at least a sufficient number of patients who are beneficiaries under the state's medicaid program to equate to at least fifteen percent of the health care provider's total patient population: *Provided, however*, That the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency shall not be deemed to be an agreement under this subsection: *Provided further*, That nothing contained in this article may be deemed to, or purport to imply, any consent by any physician on the staff of any hospital or other health care institution to accepting or agreeing to deliver health care services to any beneficiary of a health care program of a division or

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See 1991 amendments attached

department of this state in any such physician's private office or practice by virtue of the fact that such physician saw such patient in connection with such physician's duties as an on-call staff physician.

(f) The administrators of the division of health, human services, workers' compensation, and the public employees insurance agency shall report to the Legislature no later than the first day of the regular session of the Legislature of the year one thousand nine hundred ninety concerning the plan or plans developed: *Provided*, That the plan or plans may be implemented prior to the delivery of such report.

(g) Nothing in this section shall be construed to give or reserve to the Legislature any further or greater power or jurisdiction over the operations or programs of the various departments and divisions affected by this article than that already possessed by the Legislature in the absence of this article.

(h) A health care provider who provides health care services to any beneficiary of a health care program of a department or division of the state pursuant to the plan or plans developed in accordance with this article may withdraw from participation in said plan or plans: *Provided*, That the health care provider shall provide written notice of withdrawal from participation in said plan or plans to the administrator of the public employees insurance agency: *Provided, however*, That a provider who has withdrawn from further participation is not required to render services to any beneficiaries under the plan or plans who are not his or her patients at the time the notice of withdrawal is provided and the provider may continue to provide services to his or her pre-existing patients for not more than forty-five days after tendering the notice of withdrawal without obligating his or her self to treat such other beneficiaries.

Withdraw a)

(i) For the purchase of health care or health care services by a health care provider participating in a plan under this section three or in a contract under subsection (d) or (e) of section four of this article on

or after the first day of September, one thousand nine hundred eighty-nine by the public employees insurance agency, the division of rehabilitation services and the division of worker's compensation, a state check shall be issued in payment thereof within sixty-five days after a legitimate uncontested invoice is actually received by such division or agency. Any state check issued after sixty-five days shall include interest at the current rate, as determined by the state tax commissioner under the provisions of section seventeen-a, article ten, chapter eleven of this code, which interest shall be calculated from the sixty-sixth day after such invoice was actually received by the division or agency until the date on which the state check is mailed to the vendor.

§16-29D-4. Prohibition on balance billing; exceptions and termination of exceptions.

(a) Except in instances involving the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency, the agreement by a health care provider to deliver services to a beneficiary of any department or division of the state which participates in a plan or plans developed under section three of this article shall be deemed to also include an agreement by that health care provider:

(1) To accept the assignment by the beneficiary of any rights the beneficiary may have to bill such division or department for, and to receive payment under such plan or plans on account of, such services; and

(2) To accept as payment in full for the delivery of such services the amount specified in plan or plans or as determined by the plan or plans. In such instances, the health care provider shall bill the division or department, or such other person specified in the plan or plans, directly for the services. The health care provider shall not bill the beneficiary or any other person on behalf of the beneficiary and, except for deductibles or other payments specified in the applicable plan or plans, the beneficiary shall not be personally liable for any of the charges, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the applicable department or divisions. The plan or plans may specify what sums are deductibles, co-payments or are otherwise payable by the beneficiary and the sums for which the health care provider may bill the beneficiary: In addition, any health care service which is not subject to payment by the plan or plans shall be the responsibility of the beneficiary and for those health care services which are not covered by the plans, there shall be no prohibition against billing the beneficiary directly.

See 1991 amendments attached

(b) The prohibitions and limitations stated in subsection (a) of this section do not apply to the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency. However, once the patient is stabilized, then the delivery of any further health care services shall be subject to subsection (a) of this section for those latter services only.

(c) The exceptions provided in this section for the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency shall not apply to health care providers under contract with a department or division plan or plans.

(d) Subsection (a), (b) and (c) of this section four shall not be applicable to those health care providers who are allopathic physicians, osteopathic physicians, or podiatrists and who enter into acceptable preferred provider contracts with the public employees insurance agency insofar as this section would apply to beneficiaries of that agency. The limitations in this subsection do not apply to the beneficiaries of any other program of any other department or division of the state or to any other type of health care provider. An acceptable preferred provider contract for the purpose of this subsection shall be one which meets

Rates

each and every one of the following factors in addition to the other elements required by a preferred provider arrangement:

(1) The contract shall set the rates of reimbursement for health care services at the eightieth percentile of the public employees insurance agency's 1988 calendar year experience in paying claims unless, after the thirty-first day of December, one thousand nine hundred eighty-nine, the director of the public employees insurance agency determines that continuing to make payments at the eightieth percentile shall not be consistent with the budgetary restrictions imposed by the Legislature upon the public employees insurance agency. In this later event, the director, after consultation with the advisory committee created under section seven of this article, may cause the rate of reimbursement to be set below the aforesaid eightieth percentile but in no event may those rates be set below the seventy-fifth percentile. In determining whether continued rates of payment of the eightieth percentile shall be consistent or inconsistent with the aforesaid budgetary restrictions, the director shall take into consideration only the current claims experience of the health care providers covered by this subsection and shall not consider the effects of the other demands upon the public employees insurance agency's resources. If a reduction in rates is necessary during a fiscal year, at the start of the following fiscal year and for the first six months thereafter, the rates of reimbursement shall revert to the aforesaid eightieth percentile;

(2) The contract applies to at least seventy percent, by the first day of July, one thousand nine hundred eighty-nine, and eighty percent by the first day of September, one thousand nine hundred eighty-nine, of the members of recognized specialties of these health care providers in the applicable region as defined by the eleven planning and development council regions authorized by section five-a, article two-d, chapter sixteen of this code as those regions exist on the effective date of this article: *Provided*, That in determining the percentages stated above in this subsection, the total number of health care providers in a given region and specialty shall not include those providers who are hospital based and who do not themselves bill or receive a fee for services delivered by them nor shall the total number include those providers who decline to deliver health care services to all beneficiaries of a health care program of all departments or divisions of the state: *Provided, however*, That the director of the public employees insurance agency may waive this factor for any individual or group of health care providers if the director ascertains that a sufficient number of providers or recognized specialists in a given region are willing to enter into or to continue with a contract to assure access to that type of health care service to the local public employees insurance agency beneficiaries;

(3) The contract provides for a utilization review and quality assurance program which is satisfactory to the public employees insurance agency;

(4) The contract provides that the beneficiaries of the public employees insurance agency shall be individually responsible for payments only as provided for by the agency's benefit plan or plans and shall bear no personal liability for payment for health care services except as provided for by the plan or plans;

(5) The contract is entered into by the first day of July, one thousand nine hundred eighty-nine;

(6) The contract shall include incentives to public employees insurance agency beneficiaries to utilize subscriber health care providers and shall also include incentives to health care providers to subscribe to a contract; and

(7) The contract shall provide that, if after the contract is entered into, later developments reveal that one or more of subparts two, three, four or six of this subsection are no longer satisfied, then the director of the public employees insurance agency, after approval by the governor, may renegotiate or terminate the contract upon giving notice of no less than thirty days

or no more that forty-five days: *Provided*, That any non-participating providers during the continuance of section four, of this article shall be permitted to set his or her rates for reimbursement at no greater than one hundred and ten percent of the rates of reimbursement set by the director at the aforesaid eightieth percentile and may make claim against the beneficiary for the balance between the amount paid by the public employee insurance agency and the rate set by the provider as described above: *Provided, however*, That any non-participating provider shall be subject to the provisions of subsection (a), (b) and (c) of section four of this article if the director of the public employee insurance agency determines in any case that a beneficiary of the public employee insurance agency does not have access to a provider who is participating in a preferred provider contract.

(e) Section four of this article shall not be applicable to hospitals which enter into prospective contracts with the public employees insurance agency for each state fiscal year insofar as this section would apply to beneficiaries of that agency. The limitations in this subsection do not apply to the beneficiaries of any other program of any other department or division of the state or to any other type of health care provider. Such contracts shall include, in addition to the other elements required by such a contract, the following factors:

(1) The contract provides for a utilization review and quality assurance program which is satisfactory to the public employees insurance agency;

(2) For the first year of the contract, the rates for health care services are determined prospectively based upon the public employee insurance agency's one thousand nine hundred eighty-nine fiscal year experience in paying the charges of each individual hospital, but taking into consideration also any adjustments to that experience that may be necessary to provide for the special concerns and needs of the state's small and rural hospitals; for each succeeding year of the contract, the rates shall be set at no less

than that of the first year but may be negotiated for a greater level;

(3) The contract provides that the beneficiaries of the public employees insurance agency shall be individually responsible for payments only as provided for by the agency's benefit plan or plans and shall bear no personal liability for payment for health care services except as provided for by the plan or plans;

(4) The contract is entered into by the first day of July, one thousand nine hundred eighty-nine unless the director of the public employees insurance agency extends this time limit for good cause;

(5) The contract shall provide by its terms that, if after the contract is entered into, later developments reveal that any one or more of the first four factors set forth in this subsection are no longer satisfied, then the director of the public employees insurance agency, after approval of the governor, may renegotiate or terminate that contract upon reasonable notice which shall not be less than thirty days nor more than forty-five days: *Provided*, That any hospital which elects not to enter into a contract shall be subject to the provisions of subsection (a), (b) and (c) of section four of this article.

(f) Section four of this article shall terminate without any further action by the Legislature on the thirtieth day of June, one thousand one hundred and ninety-one. On or before the first day of January, one thousand nine hundred ninety-one, the advisory committee created under section seven of this article and the director of the public employees insurance agency shall report to the governor and the Legislature upon the impact of the effects of the prohibition upon balance billing in this section upon the health care provider community, upon the public employees, and upon the public employees insurance agency.

§16-29D-5. Coordination of benefits.

Coordination of benefits is permitted between two or more insurance contracts or employee benefit plans

1991 Amendments

ARTICLE 29D.

STATE HEALTH CARE.

§ 16-29D-3. Agencies to cooperate and to provide plan; contents of plan; reports to Legislature; late payments by state agencies and interest thereon.

(a) All departments and divisions of the state, including, but not limited to, the bureau of employment programs, the division of health and the division of human services within the department of health and human resources; the public employees insurance agency within the department of administration; the division of rehabilitation services or such other department or division as shall supervise or provide rehabilitation; and the university of West Virginia board of trustees, as the governing board for the state's medical schools, are authorized and directed to cooperate in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of such departments and divisions and to ensure the containment of costs in the payment for such services.

(b) 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 the Legislature that nothing contained in this article 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.

(c) Such departments and divisions shall develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including the public employees insurance agency and the workers' compensation fund, the division of rehabilitation services and, to the extent permissible, the state medicaid program. The plan or plans may include, among other things, and the departments and divisions are hereby authorized to enter into:

(1) Utilization review and quality assurance programs;

(2) The establishment of a schedule or schedules of the maximum reasonable amounts to be paid to health care providers for the delivery of health care services covered by the plan or plans. Such a schedule or schedules may be either prospective in nature or cost reimbursement in nature, or a mixture of both: Provided, That any payment methods or schedules for institutions which provide inpatient care shall be institution-specific and shall, at a minimum, take into account a disproportionate share of medicaid, charity care and medical education: Provided, however, That in no event may any rate set in this article for an institutional health care provider be greater than such institution's current rate established and approved by the health care cost review authority pursuant to article twenty-nine-b [§ 16-29B-1 et seq.] of this chapter;

(3) Provisions for making payments in advance of the receipt of health care services by a beneficiary, or in advance of the receipt of specific charges for such services, or both;

(4) Provisions for the receipt or payment of charges by electronic transfers;

(5) Arrangements, including contracts, with preferred provider organizations; and

(6) Arrangements, including contracts, with particular health care providers to deliver health care services to the beneficiaries of the programs of the departments and divisions at agreed upon rates in exchange for controlled access to the beneficiary populations.

(d) The director of the public employees insurance agency shall contract with an independent actuarial company for a review every four years of the claims experience of all governmental entities whose employees participate in the public employees insurance agency program, including, but not limited to, all branches of state government, all state departments or agencies (including those receiving funds from the federal government or a federal agency), all county and municipal governments, or any other similar entities for the purpose of determining the cost of providing coverage under the program, including administrative cost, to each such governmental entity.

(e) Nothing in this section shall be construed to give or reserve to the Legislature any further or greater power or jurisdiction over the operations or programs of the various departments and divisions affected by this article than that already possessed by the Legislature in the absence of this article.

(f) For the purchase of health care or health care services by a health care provider participating in a plan under this section on or after the first day of September, one thousand nine hundred eighty-nine, by the public employees insurance agency, the division of rehabilitation services and the division of workers' compensation, a state check shall be issued in payment thereof within sixty-five days after a legitimate uncontested invoice is actually received by such division or agency. Any state check issued after sixty-five days shall include interest at the current rate, as determined by the state tax commissioner under the provisions of section seventeen-a [§ 11-10-17a], article ten, chapter eleven of this code, which interest shall be calculated from the sixty-sixth day after such invoice was actually received by the division or agency until the date on which the state check is mailed to the vendor. (1989, c. 87; 1991, cc. 16, 134.)

Effect of amendments of 1991. — Acts 1991, c. 16 rewrote the section to read as set out in the editor's note below. Acts 1991, c. 134 rewrote (a); deleted former (e), (f) and (h) and redesignated the remaining subsections accordingly; and deleted "or in a contract under subsection (d) or (e) of section four of this article" following "participating in a plan under this section" in the first sentence of present (f).

Editor's notes. — This section was amended twice in 1991, first by c. 16 and later by c. 134. Neither amendement referred to the other. The text of the section as amended by c. 134 (passed March 9, 1991 and effective 90 days from passage) is set out above. Chapter 16 (passed March 8, 1991 and effective March 8, 1991) amended the section to read: "(a) All departments and divisions of the state, including, but not limited to, the division of health and the division of human services within the department of health and human resources; the bureau of employment programs within the department of commerce, labor and environmental resources; the public employees insurance agency within the department of administration; the division of rehabilitation services or such other department or division as shall supervise or provide rehabilitation; and the West Virginia board of regents or such other department or division as shall govern the state medical schools, are authorized and directed to cooperate in order, among other things, to ensure the quality of the health care services delivered to the beneficiaries of such departments

and divisions and to ensure the containment of costs in the payment for such services.

"(b) 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 the Legislature that nothing contained in this article 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.

"(c) Such departments and divisions shall develop a plan or plans to ensure that a reasonable and appropriate level of health care is provided to the beneficiaries of the various programs including the public employees insurance agency and the workers' compensation fund, the division of rehabilitation services and, to the extent permissible, the state medicaid program. The plan or plans may include, among other things, and the departments and divisions are hereby authorized to enter into:

"(1) Utilization review and quality assurance programs;

"(2) The establishment of a schedule or schedules of the maximum reasonable amounts to be paid to health care providers for the delivery of health care services covered by the plan or plans. Such a schedule or schedules may be either prospective in nature or cost reimbursement in nature, or a mixture of both: Provided, That any payment methods or schedules for institutions which provide inpatient care shall be institution-specific and shall, at a minimum, take into account a disproportionate share of medicaid, charity care and medical education: Provided, however, That in no event may any rate set in this article for an institutional health care provider be greater than such institution's current rate established and approved by the health care cost review authority pursuant to article twenty-nine-b [§ 16-29B-1 et seq.] of this chapter;

"(3) Provisions for making payments in advance of the receipt of health care services by a beneficiary, or in advance of the receipt of specific charges for such services, or both;

"(4) Provisions for the receipt or payment of charges by electronic transfers;

"(5) Arrangements, including contracts, with preferred provider organizations; and

"(6) Arrangements, including contracts, with particular health care providers to deliver health care services to the beneficiaries of the programs of the departments and divisions at agreed upon rates in exchange for controlled access to the beneficiary populations.

"(d) The director of the public employees insurance agency shall contract with an independent actuarial company for a review every four years of the claims experience of all governmental entities whose employees participate in the public employees insurance agency program, including, but not limited to, all branches of state government, all state departments or agencies (including those receiving funds from the federal government or a federal agency), all county and municipal governments, or any other similar entities for the purpose of determining the cost of providing coverage under the program, including administrative cost, to each such governmental entity.

"(e) Except as provided in subsection (h) of this section, any health care provider who agrees to deliver health care services to any beneficiary of a health care program of a department or division of the state, including the public employees insurance agency, the state medicaid program, the workers' compensation fund and the division of rehabilitation services, the charges for which shall be paid by or reimbursed by any department or division which participates in a plan or plans as described in this section, shall be deemed to have agreed to provide health care services to the beneficiaries of health care programs of all of the other departments and divisions participating in a plan or plans: Provided, That a health care provider shall be in compliance with this subsection if the health care provider actually delivers health care services to all such patients who request such services or if the health care provider actually delivers health care services to at least a sufficient number of patients who are beneficiaries under the state's medicaid program to equate to at least fifteen percent of the health care provider's total patient population: Provided, however, That the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency shall not be deemed to be an agreement under this subsection: Provided further, That nothing contained in this article may be deemed to, or purport to imply any consent by any physician on the staff of any hospital or other health care institution to accepting or agreeing to deliver health care services to any beneficiary of a health care program of a division or department of this state in any such physician's private office or practice by virtue of the fact that such physician saw such patient in connection with such physician's duties as an on-call staff physician.

"(f) The administrators of the division of health, human services, workers' compensation, and the public employees insurance agency shall report to the Legislature no later than the first day of the regular session of the Legislature of the year one thousand nine hundred ninety concerning the plan or plans developed: Provided, That the plan or plans may be implemented prior to the delivery of such report.

"(g) Nothing in this section shall be construed to give or reserve to the Legislature any further or greater power or jurisdiction over the operations or programs of the various departments and divisions affected by this article than that already possessed by the Legislature in the absence of this article.

"(h) A health care provider who provides health care services to any beneficiary of a health care program of a department or division of the state pursuant to the plan or plans developed in accordance with this article may withdraw from participation in said plan or plans: Provided, That the health care provider shall provide written notice of withdrawal from participation in said plan or plans to the administrator of the public employees insurance agency: Provided, however, That a provider who has withdrawn from further participation is not required to render services to any beneficiaries under the plan or plans who are not his or her patients at the time the notice of withdrawal is provided and the provider may continue to provide services to his or her pre-existing patients for not more than forty-five days after tendering the notice of withdrawal without obligating his or herself to treat such other beneficiaries.

"(i) For the purchase of health care or health care services by a health care provider participating in a plan under this section or in a contract under subsection (d) or (e) of section four [§ 16-29D-4(d) or (e)] of this article on or after the first day of September, one thousand nine hundred eighty-nine, by the public employees insurance agency, the division of rehabilitation services and the division of workers' compensation, a state check shall be issued in payment thereof within sixty-five days after a legitimate uncontested invoice is actually received by such division or agency. Any state check issued after sixty-five days shall include interest at the current rate, as determined by the state tax commissioner under the provisions of section seventeen-a [§ 11-10-17a], article ten, chapter eleven of this code, which interest shall be calculated from the sixty-sixth day after such invoice was actually received by the division or agency until the date on which the state check is mailed to the vendor."

§ 16-29D-4. Prohibition on balance billing; exceptions.

(a) Except in instances involving the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency, the agreement by a health care provider to deliver services to a beneficiary of any department or division of the state which participates in a plan or plans developed under section three [§ 16-29D-3] of this article shall be considered to also include an agreement by that health care provider:

(1) To accept the assignment by the beneficiary of any rights the beneficiary may have to bill such division or department for, and to receive payment under such plan or plans on account of, such services; and

(2) To accept as payment in full for the delivery of such services the amount specified in plan or plans or as determined by the plan or plans. In such instances, the health care provider shall bill the division or department, or such other person specified in the plan or plans, directly for the services. The health care provider shall not bill the beneficiary or any other person on behalf of the beneficiary and, except for deductibles or other payments specified in the applicable plan or plans, the beneficiary shall not be personally liable for any of the charges, including any balance claimed by the provider to be owed as being the difference between that provider's charge or charges and the amount payable by the applicable department or divisions. The plan or plans may specify what sums are deductibles, copayments or are otherwise payable by the beneficiary and the sums for which the health care provider may bill the beneficiary: In addition, any health care service which is not subject to payment by the plan or plans shall be the responsibility of the

beneficiary and for those health care services which are not covered by the plans, there shall be no prohibition against billing the beneficiary directly.

(b) The prohibitions and limitations stated in subsection (a) of this section do not apply to the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency. However, once the patient is stabilized, then the delivery of any further health care services shall be subject to subsection (a) of this section for those latter services only.

(c) The exceptions provided in this section for the delivery of health care services immediately needed to resolve an imminent life-threatening medical or surgical emergency shall not apply to health care providers under contract with a department or division plan or plans. (1989, c. 87; 1991, c. 134.)

Effect of amendment of 1991. — The amendment substituted "considered" for "deemed" in (a); and deleted former (d)-(f).