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OFFICE WEST VIRGINIA
SECRETARY OF STATE

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

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Form #3

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

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

CITE AUTHORITY: W.Va. Code, Section 16-29D-7

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 3

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

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

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

Paul L Nusbaum
Authorized Signature

$7.20

Approval of Filing

I, Paul L. Nusbaum, Secretary of the Department of Health and Human Resources, do approve and consent to the filing of the attached Agency Approval of Proposed Rules, being a proposed amendment to existing Legislative Rule 69CSR3, Implementation of Omnibus Health Care Act Payment Provisions, this 27th day of August 2004.

Signed: _____

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

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period; Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 27, 2004

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) Department of Health and Human Resources, John Law, Assistant Secretary, Office of Communications and Legislative Affairs, State Capitol Complex, Bldg. 3, Room 206, 1900 Kanawha Blvd., East, Charleston, WV 25305 558-7899

LEGISLATIVE RULE TITLE: Implementation of Omnibus Health Care Act Payment Provisions (69 CSR 3)

1. Authorizing statute(s) citation

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

   July 23, 2004

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

   None

   c. Date of Public Hearing(s) ***or*** Public Comment Period ended:

   August 23, 2004

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

   Attached _____ No comments received X

b. Date of hearing or comment period:

N/A

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

N/A

d. Attach findings and determinations and reasons:

Attached N/A

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
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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

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APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Implementation of the Omnibus Health Care Act Payment Provisions

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 Payment Provisions

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:

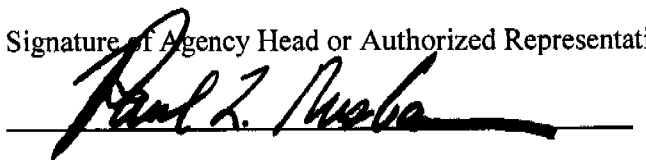
      None

   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

SERIES 3
IMPLEMENTATION OF OMNIBUS HEALTH CARE ACT
PAYMENT PROVISIONS

§69-3-1. General.

1.1. Scope. -- This legislative rule implements ~~those~~ the provisions of the Omnibus Health Care Act, W. Va. Code §16-29D-1 et seq~~., 1989, which relate to the establishment of a maximum reasonable and customary fee schedule by the Public Employees Insurance Agency, a division of the West Virginia Department of Administration, and to other reimbursement provisions.~~

1.2. Authority. -- W. Va. Code §16-29D-7.

1.3. Filing Date.

1.4. Effective Date.

§69-3-2. Definitions.

2.1. The following words and phrases as used in these rules, unless a different meaning is clearly indicated by the context, shall have the meanings stated below.

2.2. The "Act" means the Omnibus Health Care Act which is codified at W. Va. Code §16-29D-1 et seq, as amended.

~~2.3. "Actuary" means the actuarial consulting firm which established the methodology and calculated the maximum reasonable and customary fee schedule described in this rule.~~

~~2.4.~~ 2.3. "Legitimate uncontested invoice" means a claim for payment for medical services delivered to a beneficiary of a department or division subject to the Act, received by that department or division in a manner prescribed and with all information, whether from the provider, beneficiary, or other third-party payor, stipulated by that department or division, and for which there is no action necessary for coordination of benefits, subrogation or other good cause to establish the legitimacy of the claim.

~~2.5. "CPT-4 Codes" means the listing of current medical procedure terminologies developed by the American Medical Association and used by physicians and other medical providers to describe individual services provided to patients for billing and other documentary purposes.~~

~~2.6. . "Eightieth (80th) percentile maximum fee schedule" means a schedule of individual CPT-4 Code reimbursement fees set at a level that includes eighty (80) percent of the charges, by procedure, actually paid or processed for payment by the PEIA for health care services for which claims were submitted to the PEIA during the calendar year, January 1, 1988 to December 31, 1988.~~

~~2.7. "Med Index" means a fee schedule developed by Medical Data Research, Inc., Salt Lake City, Utah,~~

~~for the Charleston, West Virginia, region.~~

~~2.8. "Methodology" means the manner in which the actuary analyzed the PEIA 1988 claims data and calculated therefrom an eightieth (80th) percentile maximum fee schedule.~~

~~2.9. "1988 claims data" means the computer tape of medical claims actually paid by or submitted to and processed for payment by the PEIA during the calendar year, January 1, 1988 to December 31, 1988.~~

~~2.10. "PEIA" means the Public Employees Insurance Agency.~~

~~2.11.~~ 2.4. "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

~~§69-3-3. Purpose.~~

~~3.1. The purpose of this rule is to summarize the methodology used by the actuary to develop an eightieth (80th) percentile maximum fee schedule using the PEIA 1988 claims data. The PEIA will use this schedule to implement certain provisions of the Act, namely W. Va. Code §16-29D-4, relating to PEIA preferred provider contracts with allopathic and osteopathic physicians and podiatrists, and other health care provider reimbursement. The PEIA will set the maximum rate of reimbursement under such preferred provider contracts initially at the eightieth (80th) percentile of the PEIA's 1988 claims data. The PEIA will also adopt the eightieth (80th) percentile maximum fee schedule for all health care providers which are reimbursed based on CPT-4 Code billings: Provided, that hospitals and other institutional providers shall not be reimbursed according to the eightieth (80th) percentile maximum fee schedule, but shall be paid through individual contracts as authorized in W. Va. Code §16-29D-4(e).~~

~~3.2. Adoption of the eightieth (80th) percentile schedule by the PEIA shall be accomplished through the preferred provider contracts or changes to the PEIA group benefit plan, and not through this rule. This rule is being promulgated to comply with W. Va. Code §16-29D-7, which directs the Secretary to promulgate rules to implement the Act, and provides that methodologies for determination of rates, payments and schedules are subject to legislative rule-making procedures (but that the actual rates, payments and schedules are not).~~

3.1. This rule also interprets the provisions of W. Va. Code §16-29D-3(i) relating to prompt payment to a health care provider on or after September 1, 1989, for the purchase of health care or health care services by the PEIA, the division of rehabilitation services and the workers' compensation commission.

~~3.4. This rule is to be read with an addendum to the PEIA benefit plan document which describes current benefit changes which are being made to accommodate the provisions of this rule~~.

~~§69-3-4. Methodology~~.

~~4.1. This section summarizes the methodology employed by the actuary to develop the eightieth (80th) percentile maximum fee schedule. This rule does not attempt to delineate every task, step, computer function or calculation involved in establishing the fee schedule, but rather provides an overview of the major steps involved.~~

~~4.2. The actuary obtained on computer tape the PEIA 1988 claims data and sorted the data by CPT-4 Codes.~~

~~4.2.1. The actuary divided all CPT-4 Codes into four (4) general categories: surgery, radiology, pathology and medicine. The surgery general category was then subdivided into sixteen (16) subcategories: integumentary, musculoskeletal, respiratory, cardiovascular, hemic and lymphatic, mediastinum, digestive, urinary, male genital, intersex, female genital, maternity, endocrine, nervous, eye and ocular, and auditory.~~

~~4.2.2. For each CPT-4 Code for which the PEIA paid ten (10) or more claims in 1988, the actuary ranked the paid claims from the lowest to the highest charge. For each such code, the eightieth (80th) percentile was identified as that charge which separated the lowest eighty percent (80%) of the charges from the highest twenty percent (20%) of the charges.~~

~~4.3. The schedule of fees obtained according to subsection 4.2.1 was compared with the Med Index fee schedule to determine which fees were in the Med Index schedule, but not in the PEIA 1988 claims experience.~~

~~4.3.1. The actuary divided the Med Index fee for each CPT-4 Code by a uniform number to obtain relative values for the Med Index fees. As an illustration, if the Med Index fee for CPT-4 Code "A" was $720.00, and the Med Index fee for CPT-4 Code "B" was $900.00, then if both fees are divided by 600, the relative value for CPT-4 Code "A" becomes 1.2, and the relative value for CPT-4 Code "B" becomes 1.5.~~

~~4.3.2. For each of the nineteen (19) categories and subcategories of CPT-4 Codes, the actuary calculated the total dollar amounts paid by PEIA for each CPT-4 Code, each category and subcategory, and for the total 1988 CPT-4 claims.~~

~~4.3.2.1. Using the total dollar amounts calculated in subsection 4.3.2, the actuary compared these PEIA totals to totals calculated in a like manner for the Med Index fee schedule to identify a multiplier which would relate the Med Index relative values developed in subsection 4.3.1 to the actual PEIA 1988 claims experience. As an example, summary results of this calculation for one of the sixteen (16) surgery subcategories are:~~

~~(1) Total claims * PEIA fees at 80th = $4,708,298.04~~
~~(2) Total claims * Med Index rel.val. at $600 = $4,601,406.00~~
~~(3) Total claims * Med Index rel.val. at $613.94 = $4,708,313.48~~
~~(Adjusted multiplier to equal line (1) total claims)~~

~~4.4. The PEIA eightieth (80th) percentile maximum fee schedule was then developed for all CPT-4 Codes using the following components (in priority order):~~

~~4.4.1. The PEIA eightieth (80th) percentile fees identified in subsection 4.2.2.~~

~~4.4.2. Where the actual PEIA claims data had less than ten (10) claims paid or processed in 1988, the Med Index relative value was multiplied by the PEIA claims data multiplier calculated according to subsection 4.3.2.1.~~

~~4.4.3. Where the CPT-4 Code was one of a procedurally related series, the Med Index relative value was multiplied by a related PEIA fee identified in subsection 4.2.2.~~

~~4.5. The actuary reviewed and reanalyzed all PEIA schedule fees generated in subsection 4.4 that were 20% greater or 50% less than the current Med Index fees.~~

~~4.5.1. Each such fee was recalculated by removing the highest and lowest fees and generating a new~~

~~eightieth (80th) percentile~~.

~~4.5.1.1. Where the total number of remaining claims paid or processed was ten (10) or more, the new eightieth (80th) percentile fee was used~~.

~~4.5.1.2. Where the total number of remaining claims paid after the removal of the highest and lowest fees was less than ten (10), then a fee was calculated using the Med Index relative value and the PEIA claims experience multiplier as in subsection 4.4.2.~~

~~§69-3-5. Proprietary Nature of Fees.~~

~~5.1. Consistent with W. Va. Code §16-29D-7 and W. Va. Code §5-16-18, the actual fee schedule(s) calculated by the actuary, and any other information or calculations which would identify such fee schedule(s), are not subject to the rule-making procedures of the West Virginia Administrative Procedures Act, W. Va. Code §29A-1-1 et seq. Such fee schedule(s) and related identifying information are proprietary in nature, and will not be published or released by the Secretary or the PEIA, in order to protect and preserve competition among health care providers who may be3come subject to such schedule(s).~~

~~§69-3-6~~ § 69-3-4 Prompt Payment.

~~6.1.~~ 4.1. The PEIA, the division of rehabilitation services and the workers' compensation commission shall cause to be issued, within sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, a state check in payment for health care or health care services delivered to the respective beneficiaries of such agencies on or after September 1, 1989.

~~6.1.1.~~ **4.1.1.** If a state check is issued more than sixty-five (65) days after actual receipt by the agency of a legitimate uncontested invoice, the agency shall pay interest, at the current rate, as determined according to subsection ~~6.1.1~~ 4.1.1.1., calculated from the sixty-sixth (66th) day after such invoice was actually received by the division or agency up to and including the date on which the state check is mailed to the vendor.

~~6.1.1.1.~~ 4.1.1.1. The current rate of interest will be determined by the state tax commissioner under the provisions of W. Va. Code §11-10-17(a).

~~6.1.1.2.~~ 4.1.1.2. Each division or agency shall record by electronic or other means the actual date of receipt on all invoices received, and, if different, the date on which each invoice is deemed to be legitimate and uncontested.

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No Comments Were Received and Therefore, No Agency Amendments Were Made From The Proposed Rule, as Filed on July 23, 2004.

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

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

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.

(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

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see 1991 amendments attached

withdraw at

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.

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

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

§ 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).