WEST VIRGINIA LEGISLATURE

REGULAR SESSION, 1989

ENROLLED

Com. Sub. for Com. Sub. for

SENATE BILL NO. 576

(By Senator Tucker, Mr. President, et al)

PASSED April 8, 1989

In Effect from Passage

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COMMITTEE SUBSTITUTE
FOR

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Senate Bill No. 576

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

[Passed April 8, 1989; 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 legisla-

tive 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

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 preexisting 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

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, 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 applica-

ble 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.

(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

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 deter-

mining 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~~ than 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~~ nineteen 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

and shall be included for benefits from the public employees insurance agency and, as appropriate, from the state medicaid program, the workers' compensation fund and the division of rehabilitation services. Notwithstanding the foregoing, the workers' compensation fund shall be considered the primary payor for health care services related to work-related injuries and diseases ruled compensable as provided in article four, chapter twenty-three of this code. In no event shall the state medicaid program be considered a primary insurance contract.

§16-29D-6. Exemption from and application antitrust laws.

(a) Actions of the departments and divisions of the state, or by officers, administrators, employees, or other agents thereof, shall be exempt from antitrust action as provided in section five, article eighteen, chapter forty-seven of this code. Any actions of health care providers when made in compliance with orders, directives, rules, or regulations issued or promulgated by a department or division which participates in a plan or plans developed under section three of this article shall likewise be exempt.

(b) It is the express intention of the Legislature that the actions specified in subsection (a) of this section by either state-related persons or entities or by health care providers should also be deemed to be state actions for purposes of obtaining exemptions from federal antitrust laws.

(c) Notwithstanding subsections (a) and (b) of this section, any agreement by two or more persons, partnerships, corporations, facilities or institutions licensed, certified or authorized by law to provide professional health care services in this state to an individual during this individual's medical care, treatment or confinement, unless any of the foregoing are practicing as a partnership or are otherwise associated as a joint venture, to refrain from delivering health care services to any person or persons, which delivery would be subject to the provisions of this article, for the purpose or with the effect of fixing,

controlling, or maintaining their charges for the delivery of health care services or for the purpose or with the effect of defeating the purposes of this article shall be deemed to be unlawful under the provision of subsection (a), section three, article eighteen, chapter forty-seven of this code and shall be subject to the remedies and relief provided for in that article and chapter: *Provided*, That nothing contained in this subsection may prevent any physician on staff of any hospital or other health care institution from discussing with such hospital or health care institution the fact that such physician only consents to see the patient in connection with his or her duties as a staff on-call physician.

§16-29D-7. Rules.

The secretary of the department of health and human resources shall promulgate rules to carry out the provisions of this article. The governor shall establish an advisory committee consisting of at least five individuals representing: an administrator or a small rural hospital; an administrator of a hospital having a disproportionate share of medicaid or charity care; a registered professional nurse; a physician licensed in this state; and beneficiaries of the plan or plans. The majority of this advisory committee shall consist of health care providers. The purpose of the advisory committee is to advise and assist in the establishment of reasonable payment methods, schedule or schedules and rates. The advisory committee shall serve without compensation however, the members thereof are entitled to reimbursement of their expenses. The policies and procedures of the rate schedule process setting forth the methodology for determination of rates, payments and schedules are subject to the legislative rule-making procedures of chapter twenty-nine-a of this code: *Provided,* That emergency rules may be utilized: *Provided, however,* That the actual rates, payments and schedules themselves shall not be subject to chapter twenty-nine-a of this code.

§16-29D-8. Civil penalties; removal as provider.

The secretary of the department of health and human resources may assess a civil penalty for violation of this article. In addition to the assessments the secretary may remove the health care provider from any list of providers for whose services a department or division may pay. Upon the secretary determining there is probable cause to believe that a health care provider is knowingly violating any portion of this article, or any plan, order, directive, rule or regulation issued pursuant to this article, the secretary shall provide such health care provider with written notice which shall state the nature of the alleged violation and the time and place at which such health care provider shall appear to show cause why a civil penalty or removal from any list of providers should not be imposed, at which time and place such health care provider shall be afforded an opportunity to cross-examine the secretary's witnesses and afforded the opportunity to present testimony and enter evidence in support of its position. The hearing shall be conducted in accordance with the administrative hearings provisions of section four, article five, chapter twenty-nine-a of this code. The hearing may be conducted by the secretary or a hearing officer appointed by the secretary. The secretary or hearing officer shall have the power to subpoena witnesses, papers, records, documents, and other data in connection with the alleged violations and to administer oaths or affirmations in any such hearing. If, after reviewing the record of such hearing, the secretary determines that such health care provider is in violation of this article or any plan, order, directive, rule, or regulation issued pursuant to this article, the secretary may assess a civil penalty of not less than one thousand dollars nor more than twenty-five thousand dollars, and may remove the health care provider. Any health care provider assessed or removed shall be notified of the assessment or removal in writing and the notice shall specify the reasons for the assessment and its amount or the reasons for removal. In any appeal by the health care provider in the circuit court, the scope

of the court's review which shall include a review of the amount of the assessment and any removal as a provider, shall be as provided in section four, article five, chapter twenty-nine-a of this code for the judicial review of contested administrative cases. The provider may be removed from any list of providers, based upon the final orders of the secretary, pending final disposition of any appeal. Such removal order or penalty assessment may be stayed by the circuit court after hearing, but may not be stayed in any ex parte proceeding. If the health care provider assessed or removed has not appealed such assessments or removal and fails to pay the amount of the assessment to the secretary within thirty days, the attorney general may institute a civil action in the circuit court of Kanawha county to recover the amount of the assessment. Civil action under this section shall be handled in an expedited manner by the circuit court and shall be assigned for hearing at the earliest possible date. The remedies set forth in this section are intended only for violations of this article and shall not affect any other contractual relationship between any department or division and a health care provider.

§16-29D-9. Severability; supersedes other provisions.

If, for any reason, any part of this article or the application thereof to any person or circumstances is held unconstitutional or invalid, such unconstitutionality or invalidity shall not affect the remaining parts or their application to any other person or circumstance, and to this end, each and every part of this article is hereby declared to be severable. In the event of any inconsistency between the provisions of this article and any other provisions of this code, the provisions of this article shall prevail.

CHAPTER 23. WORKERS' COMPENSATION.

ARTICLE 4. DISABILITY AND DEATH BENEFITS.

§23-4-3. Schedule of maximum disbursements for medical, surgical, dental and hospital treatment; legislative approval; charges in excess of sche-

duled amounts not to be made; contract by employer with hospital, physician, etc., prohibited; penalties for violation.

The commissioner shall establish and alter from time to time as he may determine to be appropriate a schedule of the maximum reasonable amounts to be paid to chiropractic physicians, medical physicians, osteopathic physicians, podiatrists, optometrists, vocational rehabilitation specialists, pharmacists, ophthalmologists, and others practicing medicine and surgery, surgeons, hospitals or other persons, firms or corporations for the rendering of treatment to injured employees under this chapter. The commissioner also, on the first day of each regular session, and also from time to time, as the commissioner may consider appropriate, shall submit the schedule, with any changes thereto, to the Legislature. The promulgation of the schedule is not subject to the legislative rule-making review procedures established in sections eleven through fifteen, article three, chapter twenty-nine-a of this code.

The commissioner shall disburse and pay from the fund for such personal injuries to such employees as may be entitled thereto hereunder as follows:

(a) Such sums for medicines, medical, surgical, dental and hospital treatment, crutches, artificial limbs and such other and additional approved mechanical appliances and devices, as may be reasonably required.

(b) Payment for such medicine, medical, surgical, dental and hospital treatment, crutches, artificial limbs and such other and additional approved mechanical appliances and devices authorized under subdivision (a) hereof may be made to the injured employee, or to the person, firm or corporation who or which has rendered such treatment or furnished any of the items specified above, or who has advanced payment for same, as the commissioner may deem proper, but no such payments or disbursements shall be made or awarded by him unless duly verified statements on forms prescribed by the commissioner shall be filed

with the commissioner within two years after the cessation of such treatment or the delivery of such appliances: *Provided,* That no payment hereunder shall be made unless such verified statement shows no charge for or with respect to such treatment or for or with respect to any of the items specified above has been or will be made against the injured employee or any other person, firm or corporation, and when an employee covered under the provisions of this chapter is injured in the course of and as a result of his employment and is accepted for medical, surgical, dental or hospital treatment, the person, firm or corporation rendering such treatment is hereby prohibited from making any charge or charges therefor or with respect thereto against the injured employee or any other person, firm or corporation which would result in a total charge for the treatment rendered in excess of the maximum amount set forth therefor in the commissioner's schedule established as aforesaid.

(c) No employer shall enter into any contracts with any hospital, its physicians, officers, agents or employees to render medical, dental or hospital service or to give medical or surgical attention therein to any employee for injury compensable within the purview of this chapter, and no employer shall permit or require any employee to contribute, directly or indirectly, to any fund for the payment of such medical, surgical, dental or hospital service within such hospital for such compensable injury. Any employer violating this section shall be liable in damages to his employees as provided in section eight, article two of this chapter, and any employer or hospital or agent or employee thereof violating the provisions of this section shall be guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not less than one hundred dollars nor more than one thousand dollars or by imprisonment not exceeding one year, or both: *Provided*, That the foregoing provisions of this subdivision (c) shall not be deemed to prohibit an employer from participating in a preferred provider organization or program or a health maintenance organization or other medical cost

containment relationship with the providers of medical, hospital or other health care: *Provided, however*, That nothing in this section shall be deemed to restrict the right of a claimant to select a health care provider for treatment of a compensable injury or disease.

(d) When an injury has been reported to the commissioner by the employer without protest, the commissioner may pay, or order an employer who or which made the election and who or which received the permission mentioned in section nine, article two of this chapter to pay, within the maximum amount provided by schedule established by the commissioner as aforesaid, bills for medical or hospital services without requiring the injured employee to file an application for benefits.

(e) The commissioner shall provide for the replacement of artificial limbs, crutches, hearing aids, eyeglasses and all other mechanical appliances provided in accordance with this section which later wear out, or which later need to be refitted because of the progression of the injury which caused the same to be originally furnished, or which are broken in the course of and as a result of the employee's employment. The fund or self-insured employer shall pay for these devices, when needed, notwithstanding any time limits provided by law.

Notwithstanding the foregoing, the commissioner may establish fee schedules, make payments and take other actions required or allowed pursuant to article twenty-nine-d, chapter sixteen of this code.

CHAPTER 29. MISCELLANEOUS BOARDS AND OFFICERS.

ARTICLE 12. STATE INSURANCE.

§29-12-5c. Insurance for damages allegedly resulting from obstetric treatment of medicaid patients.

In accordance with the provisions of this article, the state board of risk and insurance management shall provide appropriate professional or other liability insurance for all medical practitioners who provide

obstetric treatment to patients which is reimbursed or reimbursable by state medicaid funds. Said insurance shall cover any claim, demand, action, suit or judgement by reason of alleged negligence or other act in the course of providing such obstetric treatment which results in illness, injury or other compensable damages, if, at the time of the alleged negligence or other act, the practitioner knew or believed that the services which he or she was providing were reimbursable or would be reimbursed by state medicaid funds. Such insurance coverage shall be in an amount to be determined by the state board of risk and insurance management, but in no event less than one million dollars for each occurrence.

The insurance policy shall include a provision for the payment of the cost of attorney's fees in connection with any claim, demand, action, suit or judgment arising from such alleged negligence or other act resulting in illness, injury or other compensable damages under the conditions specified in this section.

The insurance coverage specified in this section shall not apply to any hospital which is the site of the obstetric treatment or to any employee of said hospital, except that a practitioner providing the obstetric treatment who is also an employee of the hospital which is the site of the treatment shall be included in the insurance coverage required by this section.

The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originated in the Senate.

In effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker House of Delegates

The within ..... this the .....

day of ....., 1989.

Governor

PRESENTED TO THE
GOVERNOR
Date 4/19/89
Time 10:48