WEST VIRGINIA CODE CHAPTER 16 ARTICLE 29D

§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 Bureau of Employment Programs; the Bureau of Medical Services; the Public Employees Insurance Agency within the Department of Administration; the Division of Rehabilitation Services; the Workers' Compensation Commission; or the 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 the departments and divisions and to ensure the containment of costs in the payment for 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) The 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. The 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 the 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 the 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 entity for the purpose of determining the cost of providing coverage under the program, including administrative cost, to each 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 September 1, 1989, by the Public Employees Insurance Agency, the Division of Rehabilitation Services and the workers' compensation commission, a state check shall be issued in payment thereof within sixty-five days after a legitimate uncontested invoice is actually received by the division, commission 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. The interest shall be calculated from the sixty-sixth day after the invoice was actually received by the commission 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 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.

§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 of 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 Human Services 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 of 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 Human Services 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 $1,000 nor more than $25,000, 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.