WEST VIRGINIA CODE CHAPTER 5 ARTICLE 16B

WV Legislature

§5-16B-1. Expansion of health care coverage to children; continuation of program; legislative directives.

(a) It is the intent of the Legislature to expand access to health services for eligible children and to pay for this coverage by using private, state, and federal funds to purchase those services or purchase insurance coverage for those services. To achieve this intention, the West Virginia Children's Health Insurance Program heretofore created shall be continued and administered by the Department of Human Services, in accordance with the provisions of this article and the applicable provisions of Title XXI of the Social Security Act of 1997: *Provided*, That on and after July 1, 2022, the agencies, boards and programs including all of the allied, advisory, affiliated, or related entities and funds associated with the Children's Health Insurance Program and Children's Health Insurance Agency, shall be incorporated in and administered as a part of the Bureau for Medical Services. Participation in the program may be made available to families of eligible children, subject to eligibility criteria and processes to be established, which does not create an entitlement to coverage in any person. Nothing in this article requires any appropriation of State General Revenue Funds for the payment of any benefit provided in this article. If this article conflicts with the requirements of federal law, federal law governs.

(b) In developing a Children's Health Insurance Program that operates with the highest degree of simplicity and governmental efficiency, the director shall avoid duplicating functions available in existing agencies and may enter into interagency agreements for the performance of specific tasks or duties at a specific or maximum contract price.

(c) In developing benefit plans, the director may consider any cost savings, administrative efficiency, or other benefit to be gained by considering existing contracts for services with state health plans and negotiating modifications of those contracts to meet the needs of the program.

(d) In order to enroll as many eligible children as possible in the program created by this article and to expedite the effective date of their health insurance coverage, the director shall develop and implement a plan whereby applications for enrollment may be taken at any primary care center or other health care provider, as determined by the director, and transmitted electronically to the program's offices for eligibility screening and other necessary processing. The director may use any funds available to the agency in the development and implementation of the plan, including grant funds or other private or public moneys.

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§5-16B-2. Definitions.

As used in this article, unless the context clearly requires a different meaning:

"Agency" means the Children’s Health Insurance Agency, a division within the Bureau for Medical Services.

"Board" means the Children’s Health Insurance Program Advisory Board.

"Commissioner" means the Commissioner of the Bureau for Medical Services appointed by the Secretary of the Department of Human Services.

"Director" means the deputy commissioner within the Bureau for Medical Services who has responsibility for the operation and oversight of the Children's Health Insurance Agency.

"Essential community health service provider" means a health care provider that:

(1) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations which constitute a significant portion of its patient population or, in the case of a sole community provider, serves medically indigent patients within its medical capability; and

(2) Either waives service fees or charges fees based on a sliding scale and does not restrict access or services because of a client’s financial limitations. Essential community health service provider includes, but is not limited to, community mental health centers, school health clinics, primary care centers, pediatric health clinics or rural health clinics.

"Program" means the West Virginia Children’s Health Insurance Program.

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§5-16B-3. Reporting requirements.

(a) Annually on January 1, the director shall report to the Governor and the Legislature regarding the number of children enrolled in the program; the average annual cost per child per program; the estimated number of remaining uninsured children; and the outreach activities for the previous year. The report shall include any information that can be obtained regarding the prior insurance and health status of the children enrolled in programs created pursuant to this article. The report shall include information regarding the cost, quality, and effectiveness of the health care delivered to enrollees of this program; satisfaction surveys; and health status improvement indicators. The agency, in conjunction with other state health and insurance agencies, shall develop indicators designed to measure the quality and effectiveness of children's health programs, which information shall be included in the annual report.

(b) On a quarterly basis, the director shall provide reports to the Legislative Oversight Commission on Health and Human Resources Accountability on the number of children served, including the number of newly enrolled children for the reporting period and current projections for future enrollees; outreach efforts and programs; statistical profiles of the families served and health status indicators of covered children; the average annual cost of coverage per child; the total cost of children served by provider type, service type, and contract type; outcome measures for children served; reductions in uncompensated care; performance with respect to the financial plan; and any other information as the Legislative Oversight Commission on Health and Human Resources Accountability may require.

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§5-16B-4. Children's health policy advisory board created; qualifications and removal of members; powers; duties; meetings; and compensation.

(a) There is hereby created the West Virginia children's health insurance advisory board, which shall consist of the Director of the Public Employees Insurance Agency, the Secretary of the Department of Human Services, or his or her designee, and six citizen members appointed by the Governor, one of whom shall represent children's interests and one of whom shall be a certified public accountant, to assume the duties of the office immediately upon appointment. A member of the Senate, as appointed by the Senate President and a member of the House of Delegates, as appointed by the Speaker of the House of Delegates, shall serve as ex officio members. All appointments shall be for terms of three years, except that an appointment to fill a vacancy shall be for the unexpired term only: *Provided*, That the citizen members appointed prior to July 1, 2022, shall serve for the remainder of his or her term of appointment and be deemed a member of the advisory board. Three of the citizen members shall have at least a bachelor's degree and experience in the administration or design of public or private employee or group benefit programs and the children's representative shall have experience that demonstrates knowledge in the health, educational, and social needs of children. No more than three citizen members may be members of the same political party and no board member may represent or have a pecuniary interest in an entity reasonably expected to compete for contracts under this article. Members of the board shall assume the duties of the office immediately upon appointment. The director of the agency shall serve as the chairperson of the board. Vacancies in the board shall be filled in the same manner as the original appointment.

(b) The purpose of the advisory board is to present recommendations and alternatives for the design of the annual plans and to advise the director with respect to other actions necessary to be undertaken in furtherance of this article.

(c) The board shall meet by the call of the director.

(d) Each member of the advisory board shall receive reimbursement for reasonable and necessary travel expenses for each day actually served in attendance at meetings of the board in accordance with the state's travel rules. Requisitions for the expenses shall be accompanied by an itemized statement, which shall be filed with the auditor and preserved as a public record.

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§5-16B-4a.

Repealed.

Acts, 2010 Reg. Sess., Ch. 32.

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§5-16B-5. Director of the Children's Health Insurance Program; qualifications; powers and duties.

(a) The commissioner shall appoint an individual in the classified service as a deputy commissioner to serve as the director who shall be responsible for the implementation, administration, and management of the Children's Health Insurance Program created under this article. The director shall have at least a bachelor's degree and a minimum of three years' experience in health insurance administration.

(b) The director shall employ any administrative, technical, and clerical employees that are required for the proper administration of the program and for the work of the board.

(c) The director is responsible for the administration and management of the program and may make all rules necessary to effectuate the provisions of this article. Nothing in this article may be construed as limiting the director's otherwise lawful authority to manage the program on a day-to-day basis.

(d) The director may execute any contracts that are necessary to effectuate the provisions of this article. The provisions of §5A-3-1 *et seq*. of this code, relating to the division of purchasing of the department of finance and administration, may not apply to any contracts for any health insurance coverage, health services, or professional services authorized to be executed under the provisions of this article: *Provided*, That before entering into any contract, the director shall invite competitive bids from all qualified entities and shall deal directly with those entities in presenting specifications and receiving quotations for bid purposes. The director shall award those contracts on a competitive basis taking into account the experience of the offering agency, corporation, insurance company, or service organization. Before any proposal to provide benefits or coverage under the plan is selected, the offering agency, corporation, insurance company, or service organization shall provide assurances of utilization of essential community health service providers to the greatest extent practicable. In evaluating these factors, the director may employ the services of independent, professional consultants. The director shall then award the contracts on a competitive basis.

(e) The director shall issue requests for proposals on a regional or statewide basis from essential community health service providers for defined portions of services under the children's health insurance plan and shall, to the greatest extent practicable, either contract directly with, or require participating providers to contract with, essential community health service providers to provide the services under the plan.

(f) The director may require reinsurance of primary contracts, as contemplated in the provisions of §33-4-15 and §33-4-15a of this code.

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§5-16B-6. Financial plans requirements.

(a) *Benefit plan design*. — All financial plans required by this section shall establish: (1) the design of a benefit plan or plans; (2) the maximum levels of reimbursement to categories of health care providers; (3) any cost containment measures for implementation during the applicable fiscal year; and (4) the types and levels of cost to families of covered children. To the extent compatible with simplicity of administration, fiscal stability, and other goals of the program established in this article, the financial plans may provide for different levels of costs based on ability to pay.

(b) *Annual plans*. — The director shall review implementation of the current financial plan in light of actual experience and shall prepare an annual financial plan for each ensuing fiscal year. The director shall solicit comments in writing from interested and affected persons. The agency shall submit its final, approved financial plan, subject to the actuarial requirements of this article, to the Legislature no later than September 1, preceding the fiscal year. The financial plan for a fiscal year becomes effective and shall be implemented by the director on July 1, of that fiscal year. Annual plans developed pursuant to this subsection are subject to the provisions of subsection (a) of this section and the following guidelines:

(1) The aggregate actuarial value of the plan established as the benchmark plan should be considered as a targeted maximum or limitation in developing the benefits package;

(2) All estimated program and administrative costs, including incurred but not reported claims, may not exceed 90 percent of the funding available to the program for the applicable fiscal year; and

(3) The state's interest in achieving health care services for all its children at less than 200 percent of the federal poverty guideline shall take precedence over enhancing the benefits available under this program.

(c) The provisions of §29A-1-1 *et seq*. of this code do not apply to the preparation, approval and implementation of the financial plans required by this section.

(d) The director shall review implementation of the current financial plan each quarter and, using actuarial data, shall make those modifications to the plan that are necessary to ensure its fiscal stability and effectiveness of service. The director may not increase the types and levels of cost to families of covered children during the quarterly review except in the event of a true emergency. The agency may not expand the population of children to whom the program is made available except in its annual plan: *Provided*, That upon the effective date of this article, the director may expand coverage to any child eligible under the provisions of Title XXI of the Social Security Act of 1997: *Provided, however*, That the agency shall implement cost-sharing provisions for children who may qualify for the expanded coverage and whose family income exceeds 150 percent of the federal poverty guideline. The cost-sharing provisions may be imposed through any one or a combination of the following:

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enrollment fees, premiums, copayments, and deductibles.

(e) The agency may develop and implement programs that provide for family coverage or employer subsidies, or both, within the limits authorized by the provisions of Title XXI of the Social Security Act of 1997 or the federal regulations promulgated thereunder: *Provided*, That any family health insurance coverage offered by or through the program shall be structured so that the agency assumes no financial risk.

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§5-16B-6a. Required coverage for patient cost of clinical trials and autism spectrum disorder treatment.

Health insurance provided by the program, including coverage provided through a contract with a managed care corporation, shall include coverage of: (i) The patient cost of clinical trials, to the same extent as such coverage is mandated for the public employees insurance program by §5-16-7d and §5-16-7e of this code; and (ii) the diagnosis, evaluation and treatment of autism spectrum disorders for individuals ages 18 months to 18 years, to the same extent as such coverage is mandated for the public employees insurance program by §5-16-7(a)(8) of this code.

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§5-16B-6b. Definitions.

[Repealed.]

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§5-16B-6c. Modified benefit plan for children of families of low income between two hundred and three hundred percent of the poverty level.

[Repealed.]

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§5-16B-6d. Modified benefit plan implementation.

(a) Upon approval by the Centers for Medicare and Medicaid Services, the agency shall implement a benefit plan for uninsured children of families with income between 200 and 300 percent of the federal poverty level.

(b) The benefit plans offered pursuant to this section shall include services determined to be appropriate for children but may vary from those currently offered by the agency.

(c) The agency shall structure the benefit plans for this expansion to include premiums, coinsurance or copays, and deductibles. The agency shall develop the cost-sharing features in such a manner as to keep the program fiscally stable without creating a barrier to enrollment. The features may include different cost-sharing features within this group based upon the percentage of the federal poverty level.

All provisions of §5-16B-1 *et seq*. of this code are applicable to this expansion unless expressly addressed in §5-16B-6d of this code.

(d) Nothing in §5-16B-6d of this code may be construed to require any appropriation of state general revenue funds for the payment of any benefit provided pursuant to this section, except for the state appropriation used to match the federal financial participation funds. In the event that federal funds are no longer authorized for participation by individuals eligible at income levels above 200 percent, the director shall take immediate steps to terminate the expansion provided for in this section and notify all enrollees of the termination. If federal appropriations decrease for the programs created pursuant to Title XXI of the Social Security Act of 1997, the director shall make those decreases in this expansion program before making changes to the programs created for those children whose family income is less than 200 percent of the federal poverty level.

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§5-16B-6e. Coverage for treatment of autism spectrum disorders.

[Repealed.]

WV Legislature

§5-16B-7. West Virginia children's health fund.

(a) There is hereby created in the state Treasury a special revolving fund to be known as the "West Virginia children's health fund", which shall be an interest-bearing account. All moneys deposited or accrued in this fund shall be used exclusively:

(1) To provide the state's share of the children's health fund;

(2) To cover administrative costs associated with the children's health program; and

(3) To cover outreach activities.

(b) Moneys from the following sources may be placed into the fund:

(1) All public funds appropriated by the Legislature or transferred by any public agency as contemplated or permitted by applicable federal program laws;

(2) All private moneys contributed by corporations, individuals or other entities to the fund as contemplated and permitted by applicable federal and state laws;

(3) Any accrued interest; and

(4) Federal financial participation matching the amounts referred to in subdivisions (1), (2) and (3) of this subsection, in accordance with Section 1902 (a) (2) of the Social Security Act.

(c) Any balance remaining in the children's health fund at the end of any state fiscal year shall not revert to the state Treasury but shall remain in this fund and shall be used only in a manner consistent with this article.

(d) Notwithstanding the provisions of section two, article two, chapter twelve of this code, funds of the West Virginia children's health fund may not be redesignated for any purpose other than those set forth in this subsection. All state and private moneys received by the program shall be deposited in the West Virginia consolidated investment pool with the West Virginia Investment Management Board, with the interest income a proper credit to all such funds.

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§5-16B-8. Termination and reauthorization.

The program established in this article abrogates and and has no further force and effect, without further action by the Legislature, upon the occurrence of any of the following:

(a) The date of entry of a final judgment or order by a court of competent jurisdiction which disallows the program;

(b) The effective date of any reduction in annual federal funding levels below the amounts allocated or projected, or both, in Title XXI of the Social Security Act of 1997;

(c) The effective date of any federal rule or regulation negating the purposes or effect of this article; or

(d) For purposes of subsections (b) and (c) of this section, if a later effective date for reduction or negation is specified, that date shall control.

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§5-16B-9. Public-private partnerships.

The director may work in conjunction with a nonprofit corporation organized pursuant to the corporate laws of the state, structured to permit qualification pursuant to section 501(c) of the Internal Revenue Code for purposes of assisting the children's health program and funded from sources other than the state or federal government.

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§5-16B-10. Assignment of rights; right of subrogation by children's health insurance agency to the rights of recipients of medical assistance; rules as to effect of subrogation.

(a) Definitions. — As used in this section, unless the context otherwise requires:

"Bureau" means the Bureau for Medical Services.

"Department" means the West Virginia Department of Human Services, or its contracted designee.

"Recipient" means a person who applies for and receives assistance under the Children's Health Insurance Program.

"Secretary" means the Secretary of the Department of Human Services.

"Third-party" means an individual or entity that is alleged to be liable to pay all or part of the costs of a recipient’s medical treatment and medical-related services for personal injury, disease, illness, or disability, as well as any entity including, but not limited to, a business organization, health service organization, insurer, or public or private agency acting by or on behalf of the allegedly liable third-party.

(b) Assignment of rights. —

(1) Submission of an application to the children's health insurance agency for medical assistance is, as a matter of law, an assignment of the right of the applicant or his or her legal representative, to recover from third parties past medical expenses paid for by the children's health insurance program. This assignment of rights does not extend to Medicare benefits. At the time the application is made, the children's health insurance agency shall include a statement along with the application that explains that the applicant has assigned all of his or her rights as provided in this section and the legal implications of making this assignment.

(2) This section does not prevent the recipient or his or her legal representative from maintaining an action for injuries or damages sustained by the recipient against any third party and from including, as part of the compensatory damages sought to be recovered, the amount or amounts of his or her medical expenses.

(3) The department shall be legally subrogated to the rights of the recipient against the third party.

(4) The department shall have a priority right to be paid first out of any payments made to the recipient for past medical expenses before the recipient can recover any of his or her own costs for medical care.

(5) A recipient is considered to have authorized all third parties to release to the department

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information needed by the department to secure or enforce its rights as assignee under this article.

(c) Notice requirement for claims and civil actions. —

(1) A recipient's legal representative shall provide notice to the department within 60 days of asserting a claim against a third party. If the claim is asserted in a formal civil action, the recipient's legal representative shall notify the department within 60 days of service of the complaint and summons upon the third party by causing a copy of the summons and a copy of the complaint to be served on the department as though it were named a party defendant.

(2) If the recipient has no legal representative and the third party knows or reasonably should know that a recipient has no representation then the third party shall provide notice to the department within 60 days of receipt of a claim or within 30 days of receipt of information or documentation reflecting the recipient is receiving children's health insurance program benefits, whichever is later in time.

(3) In any civil action implicated by this section, the department may file a notice of appearance and shall thereafter have the right to file and receive pleadings, intervene, and take other action permitted by law.

(4) The department shall provide the recipient and the third party, if the recipient is without legal representation, notice of the amount of the purported subrogation lien within 30 days of receipt of notice of the claim. The department shall provide related supplements in a timely manner, but no later than 15 days after receipt of a request for same.

(d) Notice of settlement requirement. —

(1) A recipient or his or her representative shall notify the department of a settlement with a third party and retain in escrow an amount equal to the amount of the subrogation lien asserted by the department. The notification shall include the amount of the settlement being allocated for past medical expenses paid for by the Medicaid program. Within 30 days of the receipt of any such notice, the department shall notify the recipient of its consent or rejection of the proposed allocation. If the department consents, the recipient or his or her legal representation shall issue payment out of the settlement proceeds in a manner directed by the secretary or his or her designee within 30 days of consent to the proposed allocation.

(2) If the total amount of the settlement is less than the department's subrogation lien, then the settling parties shall obtain the department's consent to the settlement before finalizing the settlement. The department shall advise the parties within 30 days and provide a detailed itemization of all past medical expenses paid by the department on behalf of the recipient for which the department seeks reimbursement out of the settlement proceeds.

(3) If the department rejects the proposed allocation, the department shall seek a judicial determination within 30 days and provide a detailed itemization of all past medical expenses

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paid by the department on behalf of the recipient for which the department seeks reimbursement out of the settlement proceeds.

(A) If judicial determination becomes necessary, the trial court is required to hold an evidentiary hearing. The recipient and the department shall be provided ample notice of the same and be given just opportunity to present the necessary evidence, including fact witness and expert witness testimony, to establish the amount to which the department is entitled to be reimbursed pursuant to this section.

(B) The department has the burden of proving by a preponderance of the evidence that the allocation agreed to by the parties was improper. For purposes of appeal, the trial court's decision should be set forth in a detailed order containing the requisite findings of fact and conclusions of law to support its rulings.

(4) Any settlement by a recipient with one or more third parties which would otherwise fully resolve the recipient's claim for an amount collectively not to exceed $20,000 shall be exempt from the provisions of this section.

(5) Nothing herein prevents a recipient from seeking judicial intervention to resolve any dispute as to allocation prior to effectuating a settlement with a third party.

(e) Department failure to respond to notice of settlement. — If the department fails to appropriately respond to a notification of settlement, the amount to which the department is entitled to be paid from the settlement shall be limited to the amount of the settlement the recipient has allocated toward past medical expenses.

(f) Penalty for failure to notify the department. — A legal representative acting on behalf of a recipient or third party that fails to comply with the provisions of this section is liable to the department for all reimbursement amounts the department would otherwise have been entitled to collect pursuant to this section but for the failure to comply. Under no circumstances may a pro se recipient be penalized for failing to comply with the provisions of this section.

(g) Miscellaneous provisions relating to trial. —

(1) Where an action implicated by this section is tried by a jury, the jury may not be informed at any time as to the subrogation lien of the department.

(2) Where an action implicated by this section is tried by judge or jury, the trial judge shall, or in the instance of a jury trial, require that the jury precisely identify the amount of the verdict awarded that represents past medical expenses.

(3) Upon the entry of judgment on the verdict, the court shall direct that upon satisfaction of the judgment any damages awarded for past medical expenses be withheld and paid directly to the department, not to exceed the amount of past medical expenses paid by the department on behalf of the recipient.

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(h) Attorneys’ fees. — Irrespective of whether an action or claim is terminated by judgment or settlement without trial, from the amount required to be paid to the department there shall be deducted the reasonable costs and attorneys' fees attributable to the amount in accordance with and in proportion to the fee arrangement made between the recipient and his or her attorney of record so that the department shall bear the pro-rata share of the reasonable costs and attorneys' fees: *Provided*, That if there is no recovery, the department may under no circumstances be liable for any costs or attorneys' fees expended in the matter.

(i) Class actions and multiple plaintiff actions not authorized. — Nothing in this article authorizes the department to institute a class action or multiple plaintiff action against any manufacturer, distributor, or vendor of any product to recover medical care expenditures paid for by the Medicaid program.

(j) Secretary's authority. — The secretary or his or her designee may compromise, settle, and execute a release of any claim relating to the department's right of subrogation, in whole or in part.

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