WEST VIRGINIA CODE CHAPTER 9 ARTICLE 5

§9-5-1. Exemption of grants from certain taxes and claims.

Grants of all classes of welfare assistance received under the provisions of this chapter shall be exempted from the collection of taxes except sales taxes, from levy of execution, garnishment, suggestion, and any other legal process.

§9-5-2. Release of liens and reassignment of insurance policies.

All liens and claims upon real and personal property and all assignments of insurance policies, imposed, existing or made under the provisions of chapter one, acts of the Legislature, first extraordinary session, one thousand nine hundred thirty-six, chapter one hundred five, acts of the Legislature, regular session, one thousand nine hundred thirty-nine, chapter seventy-four, acts of the Legislature, regular session, one thousand nine hundred forty-one, chapter one hundred twenty-four, acts of the Legislature, regular session, one thousand nine hundred forty-seven, and chapter one hundred forty-three, acts of the Legislature, regular session, one thousand nine hundred fifty-three, which have not been released or reassigned, shall be released or reassigned by the commissioner by the preparation, execution and acknowledgment of a release of each lien or claim and by the delivery of such release to the person or persons entitled thereto for recordation and by a reassignment of each such insurance policy to the person or persons entitled thereto.

§9-5-3. Recipient of assistance not a pauper.

A recipient of any class of welfare assistance shall not be deemed a pauper by reason of the receipt of such assistance.

§9-5-4. Penalties for false statements, etc.

Any person who obtains or attempts to obtain, or aids or abets an applicant or recipient in obtaining or attempting to obtain, by means of a willfully false statement or misrepresentation or by impersonation of any other fraudulent device:

(1) Any class of welfare assistance to which the applicant or recipient is not entitled; or

(2) Any class of welfare assistance in excess of that to which the applicant or recipient is justly entitled; shall upon conviction be punished as follows:

(a) If the aggregate value of all funds or other benefits obtained or attempted to be obtained shall be $500 or less, the person so convicted shall be guilty of a misdemeanor and, shall be fined not more than $1,000 or confined in jail not exceeding one year; or

(b) If the aggregate value of all funds or other benefits obtained or attempted to be obtained shall exceed $500, the person so convicted shall be guilty of a felony and, shall be fined not more than $5,000 or confined in the penitentiary not less than one year nor more than five years.

§9-5-5. Recipients of cash grants.

Within such limitations as may be imposed by applicable federal laws, rules and regulations, the department of welfare shall make available for public inspection by the thirtieth day of each month a separate alphabetical list of the names and addresses of all persons receiving any class of welfare assistance in the form of cash grants during the preceding month, together with the amounts of such cash grants. This information shall be delivered to the clerk of each county court in the state who shall immediately file the same in his office with respect to persons receiving such cash grants as residents of that county. Such information shall be retained in the files of said clerks of the county courts for a period of two years from the date of receipt thereof. All information other than names, addresses and amounts of such cash grants shall be considered as confidential.

It shall be unlawful, for commercial or political purposes of any nature, for any person or persons, body, association, firm, corporation or other agency to solicit, disclose, receive, make use of, or to authorize, knowingly permit, participate in, or acquiesce in the use of, any lists of names of, or any information concerning, persons applying for or receiving any class of welfare assistance, directly or indirectly derived from the records, papers, files, or communications of the department of welfare or acquired in the course of performance of official duties. The violation of this provision is a misdemeanor, punishable upon conviction, by a fine of not more than $1,000 or imprisonment of not more than six months, or both.

For the protection of applicants and recipients of welfare assistance, the department shall be required to establish reasonable rules and regulations governing the custody, use and preservation of the records, papers, files and communications of the department.

§9-5-6. Attorney general and prosecuting attorneys to render legal services to commissioner.

The Attorney General of the state and his assistants, and the prosecuting attorneys of the various counties shall render to the commissioner, without additional compensation, such legal services as he shall require of them in the discharge of his duties. This section shall not be construed to prohibit the department from developing plans for cooperation with courts, prosecuting attorneys, and other law-enforcement officials in such a manner as to permit the state and its citizens to obtain maximum fiscal benefits under federal laws, rules and regulations.

§9-5-7. Visitation by county employees.

Health officers, physicians, and nurses employed by the county shall, at the request of the commissioner, make home visits to indigent persons.

§9-5-8. Authority to examine witnesses, administer oaths and take affidavits.

[Repealed.]

§9-5-8a. Authority to subpoena witnesses and documents when investigating the provision of medical assistance programs.

[Repealed.]

§9-5-8b. Authority of Investigations and Fraud Management Division to subpoena witnesses and documents.

[Repealed.]

§9-5-9. Direct cremation or direct burial expenses for indigent persons.

(a) For the purposes of this section:

"Direct burial" means the removal of the remains from the place of death; casket for the deceased and transportation to a West Virginia cemetery.

"Direct cremation" includes the removal of the remains from the place of death; container; and crematory fees.

"Spouse" means the person to whom the decedent was legally married and who survived the decedent: *Provided*, That a petition for divorce had not been filed by either the decedent or the spouse prior to the decedent's death.

(b) The Department of Health shall pay for direct cremation or direct burial for indigent persons in an amount not to exceed the actual cost of the direct cremation or direct burial service provided, or $1,000 whichever is less.

(c) Prior to paying for direct cremation or direct burial, the department shall determine the financial assets of a deceased person and whether or not the deceased's estate or any of his or her relatives who are liable for the direct cremation or direct burial expenses pursuant to subsection (d) of this section is financially able to pay, alone or in conjunction, for the direct cremation or direct burial expenses. The department shall require that an affidavit be filed with the department, in a form provided by and determined in accordance with the income guidelines as set forth by the department, as well as any other supporting financial information the department may require, including, but not limited to, bank statements and income tax information of the deceased person and the relatives of the deceased person who are liable for the direct cremation or direct burial expenses pursuant to section nine of this article. The affidavit must be:

(1) Signed by the heir or heirs-at-law and state that the estate of the deceased person is unable to pay the costs associated with direct cremation or direct burial and that the sole or combined assets of the heir or heirs-at-law are not sufficient to pay for the direct cremation or direct burial of the deceased person; or

(2) Signed by the county coroner or the county health officer, the attending physician or other person signing the death certificate or the state medical examiner stating that the deceased person has no heirs or that heirs have not been located after a reasonable search and that the deceased person had no estate or the estate is pecuniarily unable to pay the costs associated with direct cremation or direct burial.

(d) The relatives of an indigent person, who are of sufficient ability, shall be liable to pay the direct cremation or direct burial expenses in the following order:

(1) The spouse.

(2) The children.

(3) The parents.

(4) The brothers and sisters.

(e) The department may proceed by motion in the circuit court of the county in which the indigent person may be, against one or more of the relatives liable.

(f) If a relative so liable does not reside in this state and has no estate or debts due him or her within the state by means of which the liability can be enforced against him or her, the other relatives shall be liable as provided by this section.

(g) The liability of the relative of an indigent person for funeral service expenses is limited to the amount paid by the department.

(h) Payment for direct burials or direct cremations for indigents shall be made by the department to the West Virginia funeral director licensed pursuant to §30-6-9 of this code or a crematory operator certificated pursuant to §30-6-11 of this code that provided the direct burial or direct cremation, as the department may determine, pursuant to appropriations for expenditures made by the Legislature. Nothing in this section shall prohibit a family from holding a memorial service for the indigent person: *Provided*, That payment under this section is limited to direct burial and direct cremation and may not include payment for a memorial service.

(i) In the event that no family members can be found, or refuse to participate, an application for payment of direct cremation or direct burial for indigent persons may be submitted to the department by the provider of such services.

(j) A direct cremation may not be made of the decedent if objectionable pursuant to decedent's religion or otherwise prohibited by federal law, state law or regulation, in which case, alternate funeral service expenses shall be substituted. In the absence of a religious objection or prohibition by federal law, state law or regulation, an indigent for which payment under this section is authorized shall be cremated.

(k) A person who knowingly swears falsely in an affidavit required by this section shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $1,000 or confined in jail for a period of not more than six months, or both fined and confined.

§9-5-10. Continuation of present aid; contributions by counties.

Except as otherwise provided in this chapter, aid or assistance rendered under existing law shall not be deemed to be discontinued.

County courts may contribute in-kind services or money into a special fund of the state department of welfare to expand the general welfare programs for citizens of its county. No part of this fund shall revert to the general revenue of the state.

§9-5-11. Definitions; Assignment of rights; right of subrogation by the department for third-party liability; notice requirement for claims and civil actions; notice requirement for settlement of third-party claim; penalty for failure to notify the department; provisions related to trial; attorneys fees; class actions and multiple plaintiff actions not authorized; and Secretary's authority to settle.

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

(1) "Bureau" means the Bureau for Medical Services.

(2) "Department" means the Department of Human Services, or its contracted designee.

(3) "Recipient" means a person who applies for and receives assistance under the Medicaid Program.

(4) "Secretary" means the Secretary of the Department of Human Services.

(5) "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 department 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 Medicaid program.

(2) At the time an application for medical assistance is made, the department 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.

(3) This assignment of rights does not extend to Medicare benefits.

(4) 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 amounts of his or her past medical expenses.

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

(6) 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.

(7) A recipient is considered to have authorized all third-parties to release to the department information needed by the department to secure or enforce its rights as assignee under this chapter.

(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 sixty days of receipt of a claim or within thirty days of receipt of information or documentation reflecting the recipient is receiving Medicaid 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 thirty days of receipt of notice of the claim. The department shall provide related supplements in a timely manner, but no later than fifteen 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 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 shall have 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, identify precisely 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.

(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 shall 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 shall authorize 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.

§9-5-11a. Notice of action or claim.

If either the medical assistance recipient or the department brings an action or claim against a third person, the recipient, his or her attorney or such department shall, within thirty days of filing the action, give to the other written notice of the action or claim by certified mail. This notice shall contain the name of the third person and the court in which the action is brought. If the department institutes said action, the notice shall advise the recipient of their right to bring such action in their own name, in which they may include as a part of their claim the sums claimed by such department. Proof of such notice shall be filed in said action subject to the notice and intent procedure as outlined in section eleven of this article. If an action or claim is brought by either the recipient or the department, the other may, at any time before trial, become a party to the action, or shall consolidate his or her action or claim with the other if brought independently: *Provided*, That this consolidation or entry as a party does not delay the proceedings.

§9-5-11b. Release of information.

(a) All recipients of medical assistance under the Medicaid program are considered to have authorized all third parties, including, but not limited to, insurance companies and providers of medical care, to release to the department information needed by the department to secure or enforce its rights as assignee under this chapter.

(b) As a condition of doing business in the state, health insurers, including self-insured plans, group health plans as defined in §6074(a) of the Employee Retirement Income Security Act of 1974, service benefit plans, third-party administrators, managed care organizations, pharmacy benefit managers or other parties that are by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service are required to comply with the following:

(1) Upon the request of the Bureau for Medical Services, or its contractor, provide information to determine the period that the service recipients, their spouse or dependents may be or may have been covered by the health insurer, including the nature of the coverage that is or was provided by the health insurer, the name, address, date of birth, Social Security number, group number, identifying number of the plan, and effective and termination dates. The information shall be provided in a format suitable for electronic data matches, conducted under the direction of the department, no less than monthly or as prescribed by the secretary. The health insurer must respond within sixty working days after receipt of a written request for enrollment data from the department or its contractor;

(2) Accept the right of the Bureau for Medical Services of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made by the Bureau for Medical Services;

(3) Respond to any inquiry by the Bureau for Medical Services regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(4) Accept a claim submitted by the Bureau for Medical Services regardless of the date of submission of the claim, the type or format of the claim form, lack of preauthorization or the failure to present proper documentation at the point-of-sale that is the basis of the claim: *Provided*, That the claim is submitted by the Bureau for Medical Services within the three-year period beginning on the date on which the item or service was furnished and any action by the Bureau for Medical Services to enforce its right with respect to the claim is commenced within six years of the Bureau for Medical Services' submission of the claim.

§9-5-11c. Right of the department to recover medical assistance.

(a) Upon the death of a person who was fifty-five years of age or older at the time the person received welfare assistance consisting of nursing facility services, home and community-based services, and related hospital and prescription drug services, the department, in addition to any other available remedy, may file a claim or lien against the estate of the recipient for the total amount of medical assistance provided by Medicaid for nursing facility services, home and community-based services, and related hospital and prescription drug services provided for the benefit of the recipient. Claims so filed shall be classified as and included in the class of debts due the state.

(b) The department may recover pursuant to subsection (a) only after the death of the individual's surviving spouse, if any and only after such time as the individual has no surviving children under the age of twenty-one, or when the individual has no surviving children who meet the Social Security Act's definition of blindness or permanent and total disability.

(c) The state shall have the right to place a lien upon the property of individuals who are inpatients in a nursing facility, intermediate care facility for individuals with an intellectual disability or other medical institution who, after notice and an opportunity for a hearing, the state has deemed to be permanently institutionalized. This lien shall be in an amount equal to Medicaid expenditures for services provided by a nursing facility, intermediate care facility for individuals with an intellectual disability or other medical institution, and shall be rendered against the proceeds of the sale of property except for a minimal amount reserved for the individual's personal needs. Any such lien dissolves upon that individual's discharge from the medical institution. The secretary has authority to compromise or otherwise reduce the amount of this lien in cases where enforcement would create a hardship.

(d) No lien may be imposed on such individual's home when the home is the lawful residence of: (1) The spouse of the individual; (2) the individual's child who is under the age of twenty-one; (3) the individual's child meets the Social Security Act's definition of blindness or permanent and total disability; or (4) the individual's sibling has an equity interest in the home and was residing in the home for a period of at least one year immediately before the date of the individual's admission to a medical institution.

(e) The filing of a claim, pursuant to this section, neither reduces or diminishes the general claims of the department, except that the department may not receive double recovery for the same expenditure. The death of the recipient neither extinguishes or diminishes any right of the department to recover. Nothing in this section affects or prevents a proceeding to enforce a lien pursuant to this section or a proceeding to set aside a fraudulent conveyance.

(f) Any claim or lien imposed pursuant to this section is effective for the full amount of medical assistance provided by Medicaid for nursing facility services, home and community-based services, and related hospital and prescription drug services. The lien attaches and is

perfected automatically as of the beginning date of medical assistance, the date when a recipient first receives treatment for which the department may be obligated to provide medical assistance. A claim may be waived by the department, if the department determines, pursuant to applicable federal law and rules and regulations, that the claim will cause substantial hardship to the surviving dependents of the deceased.

(g) Upon the effective date of this section, the Attorney General, on behalf of the State of West Virginia, shall commence an action in a court of competent jurisdiction to test the validity, constitutionality, and the ability of the Congress of the United States to mandate the implementation of this section. This subsection does not limit the right of others, including recipients, to intervene in any litigation, nor does it limit the discretion of the Attorney General or appropriate counsel to seek affected persons to act as parties to the litigation, either individually or as a class.

§9-5-12. Medicaid program; maternity and infant care.

(a) The department shall:

(1) Extend Medicaid coverage to pregnant women and their newborn infants to 185 percent of the federal poverty level and to provide coverage up to 1-year postpartum care, effective July 1, 2021 or as soon as federal approval has occurred.

(2) As provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272, the Sixth Omnibus Budget Reconciliation Act (SOBRA), Public Law 99-509, and the Omnibus Budget Reconciliation Act (OBRA), Public Law 100-203, effective July 1, 1988, infants shall be included under Medicaid coverage with all children eligible for Medicaid coverage born after October 1, 1983, whose family incomes are at or below 100 percent of the federal poverty level and continuing until such children reach the age of eight years.

(3) Elect the federal options provided under COBRA, SOBRA, and OBRA impacting pregnant women and children below the poverty level: *Provided,* That no provision in this article shall restrict the department in exercising new options provided by or to be in compliance with new federal legislation that further expands eligibility for children and pregnant women.

(4) The department is responsible for the implementation and program design for a maternal and infant health care system to reduce infant mortality in West Virginia. The health system design shall include quality assurance measures, case management, and patient outreach activities. The department shall assume responsibility for claims processing in accordance with established fee schedules and financial aspects of the program necessary to receive available federal dollars and to meet federal rules and regulations.

(5) The department shall increase to no less than $600 the reimbursement rates under the Medicaid program for prenatal care, delivery, and post-partum care.

(b) In order to be in compliance with the provisions of OBRA through rules and regulations, the department shall ensure that pregnant women and children whose incomes are above the Aid to Families and Dependent Children (AFDC) payment level are not required to apply for entitlements under the AFDC program as a condition of eligibility for Medicaid coverage. Further, the department shall develop a short, simplified pregnancy/pediatric application of no more than three pages, paralleling the simplified OBRA standards.

(c) Any woman who establishes eligibility under this section shall continue to be treated as an eligible individual without regard to any change in income of the family of which she is a member until the end of the 1 year period beginning on the last day of her pregnancy.

(d) The department shall make payment for tubal ligation without requiring at least 30 days between the date of informed consent and the date of the tubal ligation procedure.

§9-5-12a. Medicaid program; dental care.

(a) The following terms are defined:

(1) "Cosmetic services" means dental work that improves the appearance of the teeth, gums, or bite, including, but not limited to, inlays or onlays, composite bonding, dental veneers, teeth whitening, or braces.

(2) "Diagnostic and preventative services" means dental work that maintains good oral health and includes oral evaluations, routine cleanings, x-rays, fluoride treatment, fillings, and extractions.

(3) "Restorative services" means dental work that involves tooth replacement, including, but not limited to, dentures, dental implants, bridges, crowns, or corrective procedures such as root canals.

(b) The Department of Human Services shall extend Medicaid coverage to adults aged 21 and over covered by the Medicaid program for diagnostic and preventative dental services and restorative dental services, excluding cosmetic services. This coverage is limited to $2,000 per two-year budget period. Recipients must pay for services over the $2,000 limit. No provision in this section shall restrict the department in exercising new options provided by, or to be in compliance with, new federal legislation that further expands eligibility for dental care for adult recipients.

(c) The department is responsible for the implementation of, and program design for, a dental care system to reduce the continuing harm and continuing impact on the health care system in West Virginia. The dental health system design shall include oversight, quality assurance measures, case management, and patient outreach activities. The department shall assume responsibility for claims processing in accordance with established fee schedules and financial aspects of the program necessary to receive available federal dollars and to meet federal rules and regulations. The department shall seek authority from the Centers for Medicare and Medicaid Services to implement the provisions of this section.

(d) On or before December 1, 2027, the Bureau for Medical Services shall file a report with the Legislative Oversight Commission on Health and Human Resources Accountability and the Joint Committee on Government and Finance analyzing Medicaid expenditures related solely to the dental program for the plan year immediately prior to the passage of this legislation and each plan year until the date of submission of the required report. The report shall include at a minimum an analysis of the enrollees served, the state share of the Medicaid expenditures, and the federal share of expenditures.

§9-5-13. Pilot program for certain aid recipients seeking self-employment.

(a) The Legislature finds and declares that a pilot program which allows recipients of benefits of the federal aid to families with dependent children program (AFDC), Title 42 §601 et seq., United States Code, to maintain their benefits during the start-up phase of their self-supporting business, will assist these individuals in becoming independent of all public assistance. This pilot program will provide the opportunity for AFDC recipients to improve their quality of life and to apply their entrepreneurial skills in the market place. In addition, this program will help contribute to the tax base and may provide additional jobs.

(b) The department of human services shall develop and implement during the fiscal year beginning July 1, 1987, a pilot program testing the feasibility of treating, with respect to the continuation of benefits until self sufficiency is achieved and public assistance is no longer required, the efforts of AFDC recipients to become self-employed in a similar manner as efforts are treated under other existing department programs to seek other employment or training. The pilot program shall consist of up to twenty participants in no more than five counties.

(c) Eligibility for the pilot program shall consist of current AFDC recipients selected through a voluntary, informed consent process and withdrawal from the program shall not lead to automatic loss of benefits, except that eligibility may be redetermined.

(d) During the start-up period of self-employment, which shall in no instance exceed two years, the participant shall continue receiving public assistance benefits at the level at which she or he was receiving them at the time of entry into the pilot program.

(e) A participant shall be permitted to separate business assets from personal assets during start-up activity.

(f) The department shall establish guidelines by which the AFDC recipient's business assets shall be evaluated during the start-up period as an indication that the business enterprise is providing personal income sufficient to replace to public assistance benefits and other noncash benefits which may be affected by the personal income ceiling. When the assets of the business enterprise reach that level determined to be sufficient, the AFDC recipient shall have the burden of showing why the business income is not of a level sufficient to terminate the public assistance benefits subject to provision of subsection (d) of this section.

(g) Guidelines for evaluation shall be based primarily on criteria utilized by small business loan officers and others of like expertise to determine what level of assets is necessary to maintain the type of business undertaken by the recipient. The department may establish an advisory group of persons engaged in small business or other appropriate members to establish such criteria.

(h) Individual case evaluations by these criteria shall be done in consultation with a technical assistance provider or other monitor who has had direct involvement with the participant

under review.

(i) Technical assistance shall be included in the pilot program and the department may contract with existing training programs or other qualified providers with experience relevant to pilot program participants for such technical assistance. It shall include, but not be limited to, basic business planning, fiscal management and appropriate sales or other marketing skills.

(j) Upon completion of the pilot program, if it is determined that the project was effective in achieving the objective of assisting participants to establish self-employment sufficient to relinquish public assistance benefits, the department shall implement a similar statewide program for qualified applicants.

(k) Effectiveness of the pilot program shall be evaluated by the department in consultation with members of the small business advisory group, technical assistance providers and individual case monitors.

(l) If state funding is not secured for this pilot by July 1, 1987, the department shall apply for federal waivers and explore other funding sources to implement funding of the pilot program.

§9-5-14. Medicaid program; health care facilities financed by bonds; rules regarding reimbursement of capital costs.

(a) The Legislature finds and declares that a number of health care facilities have been financed by public bonded indebtedness, and as a result of policies, rules and standards which may be in conflict, the facilities and the health and welfare of those citizens served by such facilities are in jeopardy. The provisions of subsection (b) are enacted for the purpose of addressing this as a short-term solution. The provisions of subsection (d) are enacted for the purpose of further addressing such conflicting policies, rules and standards.

(b) As to any health care facility licensed under article five-c, chapter sixteen of this code, constructed after April 1, 1981, and affected on or after that date by the reimbursement methodology implemented by the department regarding standard appraised value, beginning on April 1, 1988, and for a two-year period only, ending on March 31, 1990, all in compliance with federal rules and regulations, the department shall reimburse such health care facilities no less than any actual annual capital costs, including, but not limited to, debt service, lease payments or costs of comparable financing arrangements incurred in connection with any capital expenditure approved pursuant to article two-d, chapter sixteen of this code or any rule promulgated thereunder or in conjunction with the financing of such capital expenditure pursuant to article two-c, chapter thirteen of this code, whichever is greater; and in no event, for the purpose of reimbursement of such capital costs, may the value of any health care facility licensed pursuant to article five-c, chapter sixteen of this code be deemed to be less than the greater of the aggregate principal amount of any public bond issue undertaken pursuant to the provisions of article two-c, chapter thirteen of this code or the maximum capital expenditure approved pursuant to article two-d, chapter sixteen of this code or any rule promulgated thereunder, and any appraisal made by the department in connection therewith shall include costs related to the financing of the bond issue or the maximum capital expenditure approved pursuant to article two-d, chapter sixteen of this code, as applicable: Provided, That said values may be reduced by (A) any functional obsolescence which is determined and identified annually pursuant to any rule promulgated hereunder and (B) the pro rata share of such value which is attributable to capital expenditures incurred with respect to facilities which provide services which are not eligible for reimbursement under Title XIX of the social security act: Provided, however, That the department may not exceed the Medicare upper payment limit for Medicaid in making any reimbursement pursuant to this section.

As to any health care facility constructed after April 1, 1981, and affected on or after that date by the reimbursement methodology implemented by the department regarding standard appraised value, with respect to reimbursement to the state by such health care facility arising from adjustment of projected rates, the department shall provide for the adjustment of projected rates based upon values which are consistent with the provisions of this section and based upon the actual occupancy experience of the health care facility during the projected rate period, all in compliance with federal rules and regulations.

(c) The Medicaid payments that a long-term care facility would otherwise receive may not be

reduced in any manner as a result of the operation of this section.

(d) For the rate setting cycle beginning on April 1, 1990, and for a period ending on July 1, 1992, the department shall reimburse health care facilities described in subsection (b), with sixty or more licensed beds, for actual annual capital costs in the manner prescribed in subsection (b): Provided, That the capital costs reimbursement attributable to subsection (b) of this section may not exceed the Medicare upper payment limit based upon presumed occupancy of ninety percent or actual occupancy of the facility, whichever is greater: Provided, however, That any capital cost reimbursement attributable to the computation made pursuant to the provisions of this subsection (d) shall not exceed the per patient day cost of capital as computed under the rules of the department, without reference to this section, plus $6 per patient day. Requests for information from the department regarding reimbursement pursuant to this subsection (d) shall be completed and submitted to the department not later than sixty days subsequent to the receipt of the department's request by the facility.

The department shall provide for the adjustment of projected rates for health care facilities described in subsection (b), with sixty or more licensed beds, in the manner prescribed in subsection (b).

§9-5-15. Medicaid program; preferred drug list and drug utilization review.

The Legislature finds that it is a public necessity that trade secrets, rebate amounts, percentage of rebate, manufacturer's pricing and supplemental rebates that are contained in records, as well as any meetings at which this information is negotiated or discussed need confidentiality to insure the most significant rebates available for the state. Information pertaining to similar agreements with the federal government and negotiated by pharmaceutical manufacturers is confidential pursuant to 42 U.S.C. 1396r-8. A rebate as a percentage of average manufacture price is confidential under federal law and the federal rebate could be made known if not protected by state law. Because of the protection afforded by federal law, if this information is not protected by state law, manufacturers will not be willing to offer a rebate in West Virginia. Further, the Legislature finds that the number and value of supplemental rebates obtained by the department will increase, to the benefit of Medicaid recipients, if information related to the supplemental rebates is protected in the records of the department and in meetings in which this information is disclosed because manufacturers will be assured they will not to be placed at a competitive disadvantage by exposure of this information.

The secretary of the Department of Human Services has the authority to develop a preferred drug list, in accordance with federal law, which shall consist of federally approved drugs. The department, through administration of the Medicaid program, may reimburse, where applicable and in accordance with federal law, entities providing and dispensing prescription drugs from the preferred drug list.

The secretary is authorized to negotiate and enter into agreements with pharmaceutical manufacturers for supplemental rebates for Medicaid reimbursable drugs.

The provisions of article three, chapter five-a of this code shall not apply to any contract or contracts entered into under this section.

Trade secrets, rebate amounts, percentage of rebate, manufacturer's pricing and supplemental rebates which are contained in the department's records and those of its agents with respect to supplemental rebate negotiations and which are prepared pursuant to a supplemental rebate agreement are confidential and exempt from all of article one, chapter twenty-nine-b of this code.

Those portions of any meetings of the committee at which trade secrets, rebate amounts, percentage of rebate, manufacturer's pricing and supplemental rebates are disclosed for discussion or negotiation of a supplemental rebate agreement are exempt from all of article nine-a, chapter six of this code.

The secretary will monitor and evaluate the effects of this provision on Medicaid recipients, the Medicaid program, physicians and pharmacies.

The commissioner shall implement a drug utilization review program to assure that

prescribing and dispensing of drug products result in the most rational cost-effective medication therapy for Medicaid patients.

Any moneys received in supplemental rebates will be deposited in the medical services fund established in §9-4-2 of this code.

§9-5-16. Medicaid program; legislative purpose; health care provider reimbursement study by department; hearings; report.

(a) It is the purpose of the Legislature in enacting this section to encourage the long-term well planned development of fair and equitable reimbursement methodologies and systems for all health care providers reimbursed under the Medicaid program in its entirety, and to ensure that reimbursement for services of all such health care providers is determined without undue discrimination or preference and with full consideration of adequate and reasonable compensation to such health care providers for the costs of providing such services.

(b) In order that the Legislature become better informed as to these matters, and appropriately appraise and balance the interests among all such health care providers and between all such health care providers and the interests of all the state's citizenry, the Legislature hereby directs the commissioner of the department of human services to identify, explore, study and consider the potential benefits and risks associated with the adoption of alternative and emerging and state-of-the-art concepts in reimbursement methodology for such health care providers.

(c) Toward this end, the commissioner shall conduct inquiries and hold hearings in order to provide all health care providers and other interested persons the opportunity to comment. In carrying out the provisions of this section, the commissioner shall have jurisdiction over such persons, whether such health care providers or not, as may be in the opinion of the commissioner necessary to the exercise of the mandate set forth in this section, and may compel attendance before the department, take testimony under oath and compel the production of papers or other documents. Upon reasonable requests by the commissioner, all other state agencies shall cooperate in carrying out the provisions of this section.

(d) The commissioner shall make monthly reports to the Joint Committee on Government and Finance, created by article three, chapter four of this code, or a subcommittee designated by the Joint Committee, and at the completion of such identification, exploration, study and consideration, present to the Joint Committee or its subcommittee, no later than December 1, 1988, a summary report which shall set forth all activities pursuant to the mandate of the Legislature as set forth herein, any policy decisions reached and initiatives undertaken and findings and conclusions as well as any recommendations for legislation. The commissioner shall also make such full report to the Legislature no later than the first day of the 1989 regular session of the Legislature.

(e) Nothing in this section shall be construed to give the Legislature any jurisdiction over the Medicaid program or its operations.

§9-5-16a. Medicaid-certified nursing homes; screening of applicants and residents for mental illness; reimbursement of hospitals.

(a) The department of human services shall cause individuals applying for admission to or residing in a Medicaid-certified nursing home to be screened as required by the Omnibus Budget Reconciliation Act of 1987.

(b) Effective April 1, 1989, hospitals shall receive administrative day payment at a rate set by the Medicaid agency to reimburse the hospitals for days required for the screening of Medicaid eligible patients required by subsection (a) of this section.

(c) The Secretary of the Department of Human Services is authorized to promulgate rules and regulations to fully implement this section.

§9-5-17. Nonprofit agency or facility, in receipt of Medicaid moneys, shall provide annual accounting of gross receipts and disbursements including salaries.

Any nonprofit health care agency or facility which receives Medicaid moneys shall, as a condition of the receipt of same, provide an annual accounting of that facility's or provider's receipts and disbursements, including the total salaries of all employees and administrators, with one copy of same to be submitted to the Joint Committee on Government and Finance and one copy submitted to the health care cost review authority on or before the fifteenth day of the first month of the year, for the preceding year.

§9-5-18

Repealed

Acts, 2018 Reg. Sess., Ch. 120.

§9-5-19. Summary review for certain behavioral health facilities and services.

(a) A certificate of need as provided in article two-d, chapter sixteen of this code is not required by an entity proposing additional behavioral health care services, but only to the extent necessary to gain federal approval of the Medicaid MR/DD waiver program, if a summary review is performed in accordance with the provisions of this section.

(b) Prior to initiating any summary review, the secretary shall direct the revision of the state mental health plan as required by the provisions of 42 U.S.C. 300x and section four, article one-a, chapter twenty-seven of this code. In developing those revisions, the secretary is to appoint an advisory committee composed of representatives of the associations representing providers, child care providers, physicians and advocates. The secretary shall appoint the appropriate department employees representing regulatory agencies, reimbursement agencies and oversight agencies of the behavioral health system.

(c) If the secretary determines that specific services are needed but unavailable, he or she shall provide notice of the department's intent to develop those services. Notice may be provided through publication in the state register, publication in newspapers or a modified request for proposal as developed by the secretary.

(d) The secretary may initiate a summary review of additional behavioral health care services, but only to the extent necessary to gain federal approval of the Medicaid MR/DD waiver program, by recommending exemption from the provisions of article two-d, chapter sixteen of this code to the Health Care Authority. The recommendation is to include the following findings:

(1) That the proposed service is consistent with the state health plan and the state mental health plan;

(2) That the proposed service is consistent with the department's programmatic and fiscal plan for behavioral health services;

(3) That the proposed service contributes to providing services that prevent admission to restrictive environments or enables an individual to remain in a nonrestrictive environment;

(4) That the proposed service contributes to reducing the number of individuals admitted to inpatient or residential treatment programs or services;

(5) If applicable, that the proposed service will be community-based, locally accessible, provided in an appropriate setting consistent with the unique needs and potential of each client and his or her family and located in an area that is unserved or underserved or does not allow consumers a choice of providers; and

(6) That the secretary is determining that sufficient funds are available for the proposed service without decreasing access to or provision of existing services. The secretary may, from time to time, transfer funds pursuant to the general provisions of the budget bill.

(e) The secretary's findings required by this section shall be filed with the secretary's recommendation and appropriate documentation. If the secretary's findings are supported by the accompanying documentation, the proposal does not require a certificate of need.

(f) Any entity that does not qualify for summary review is subject to a certificate of need review.

(g) Any provider of the proposed services denied authorization to provide those services pursuant to the summary review has the right to appeal that decision to the state agency in accordance with the provisions of section ten, article two-d, chapter sixteen of this code.

§9-5-20. Medicaid program; chronic kidney disease; evaluation and classification.

(a) Any enrollee in Medicaid who is eligible for services and who has a diagnosis of diabetes or hypertension or, who has a family history of kidney disease, shall receive coverage for an evaluation for chronic kidney disease through routine clinical laboratory assessments of kidney function.

(b) Any enrollee in Medicaid who is eligible for services and who has been diagnosed with diabetes or hypertension or who has a family history of kidney disease and who has received a diagnosis of kidney disease shall be classified as a chronic kidney patient.

(c) The diagnostic criteria used to define chronic kidney disease should be those generally recognized through clinical practice guidelines which identify chronic kidney disease or its complications based on the presence of kidney damage and level of kidney function.

(d) Medicaid providers shall be educated by the Bureau for Public Health in an effort to increase the rate of evaluation and treatment for chronic kidney disease. Providers should be made aware of:

(i) Managing risk factors, which prolong kidney function or delay progression to kidney replacement therapy;

(ii) Managing risk factors for bone disease and cardiovascular disease associated with chronic kidney disease;

(iii) Improving nutritional status of chronic kidney disease patients; and

(iv) Correcting anemia associated with chronic kidney disease.

§9-5-21. Annual report to joint committee on government and finance regarding treatment for autism spectrum disorders provided by the Bureau for Medical Services.

(a) On or before January 1 each year, the agency shall file an annual report with the joint committee on government and finance describing the number of enrolled individuals with autism spectrum disorder, including the fiscal and administrative impact of treatment of autism spectrum disorders, and any recommendations the agency may have as to changes in law or policy related to such disorder. In addition, the agency shall provide such other information as may be requested by the joint committee on government and finance as it may from time to time request.

(b) For purposes of this section, the term "autism spectrum disorder" means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

§9-5-22. Medicaid managed care reporting.

(a) Beginning January 1, 2016, and annually thereafter, the Bureau for Medical Services shall submit an annual report by May of that year to the Joint Committee on Government and Finance and the Legislative Oversight Commission on Health and Human Resources Accountability that includes, but is not limited to, the following information for all managed care organizations:

(1) The name and geographic service area of each managed care organization that has contracted with the bureau.

(2) The total number of health care providers in each managed care organization broken down by provider type and specialty and by each geographic service area.

(3) The monthly average and total of the number of members enrolled in each organization broken down by eligibility group.

(4) The percentage of clean claims paid each provider type within thirty calendar days and the average number of days to pay all claims for each managed care organization

(5) The number of claims denied or pended by each managed care organization.

(6) The number and dollar value of all claims paid to non-network providers by claim type for each managed care organization.

(7) The number of members choosing the managed care organization and the number of members auto-enrolled into each managed care organization, broken down by managed care organization.

(8) The amount of the average per member per month payment and total payments paid to each managed care organization.

(9) A comparison of nationally recognized health outcomes measures as required by the contracts the managed care organizations have with the bureau.

(10) A copy of the member and provider satisfaction survey report for each managed care organization.

(11) A copy of the annual audited financial statements for each managed care organization.

(12) A brief factual narrative of any sanctions levied by the department against a managed care network.

(13) The number of members, broken down by each managed care organization, filing a grievance or appeal and the total number and percentage of grievances or appeals that reversed or otherwise resolved a decision in favor of the member.

(14) The number of members receiving unduplicated outpatient emergency services and urgent care services, broken down by managed care organization.

(15) The number of total inpatient Medicaid days broken down by managed care organization and aggregated by facility type.

(16) The following information concerning pharmacy benefits broken down by each managed care organization and by month:

(A) Total number of prescription claims;

(B) Total number of prescription claims denied;

(C) Average adjudication time for prescription claims;

(D) Total number of prescription claims adjudicated within thirty days;

(E) Total number of prescription claims adjudicated within ninety days;

(F) Total number of prescription claims adjudicated after thirty days; and

(G) Total number of prescription claims adjudicated after ninety days.

(17) The total number of authorizations by service.

(18) Any other metric or measure which the Bureau of Medical Services deems appropriate for inclusion in the report.

(19) For those managed care plans that are accredited by a national accreditation organization they shall report their most recent annual quality ranking for their Medicaid plans offered in West Virginia.

(20) The medical loss ratio and the administrative cost of each managed care organization and the amount of money refunded to the state if the contract contains a medical loss ratio.

(b) The report required in subsection (a) of this section shall also include information regarding fee-for-service providers that is comparable to that required in subsection (a) of this section for managed care organizations: Provided, That any report regarding Medicaid fee for service should be designed to determine the medical and pharmacy costs for those benefits similar to ones provided by the managed care organizations and the data shall be reflective of the population served.

(c) The report required in subsection (a) of this section shall also include for each of the five most recent fiscal years, annual cost information for both managed care organizations and fee-for-service providers of the Medicaid program expressed in terms of:

(1) Aggregate dollars expended by both managed care organizations and fee-for-service

providers of the Medicaid programs per fiscal years; and

(2) Annual rate of cost inflation from prior fiscal year for both managed care organizations and fee-for-service providers of the Medicaid program.

§9-5-23. Bureau of Medical Services information.

(a) The Bureau of Medical Services shall publish all informational bulletins, health plan advisories, and guidance published by the department concerning the Medicaid program on the department's website.

(b) The bureau shall publish all Medicaid state plan amendments and any related correspondence within twenty-four hours of receipt of the correspondence submission to the Centers for Medicare and Medicaid Services.

(c) The bureau shall publish all formal responses by the Centers for Medicare and Medicaid Services regarding any state plan amendment on the department's website within twenty-four hours of receipt of the correspondence.

§9-5-24. Requiring substance abuse treatment providers to give pregnant woman priority access to services.

Substance abuse treatment or recovery service providers that accept Medicaid shall give pregnant women priority in accessing services and shall not refuse access to services solely due to pregnancy as long as the provider's services are appropriate for pregnant women.

§9-5-25. Medicaid program compact.

[Repealed]

§9-5-26. Supplemental Medicare and Medicaid reimbursement.

(a) A ground emergency medical transportation services provider, owned, operated by, or providing services under contract to, the state, or a city, a county, or city and county, that provides services to Medicare and Medicaid beneficiaries is eligible for supplemental reimbursement.

(b) An eligible provider's supplemental reimbursement shall be calculated and paid as follows:

(1) The supplemental reimbursement to an eligible provider shall be equal to the amount of federal financial participation received as a result of the claims submitted.

(2) In no instance may the amount certified, when combined with the amount received from all other sources of reimbursement from the Medicare or Medicaid program, exceed 100 percent of actual costs, as determined pursuant to the Medicaid State Plan or the state's Medicare plan, for ground emergency medical transportation services.

(3) The supplemental Medicare and Medicaid reimbursement shall be distributed exclusively to eligible providers under a payment methodology based on ground emergency medical transportation services provided to Medicare and Medicaid beneficiaries by eligible providers on a per-transport basis or other federally permissible basis. The Department of Human Services shall obtain approval from the Centers for Medicare and Medicaid Services for the payment methodology to be used, and may not make any payment pursuant to this section prior to obtaining that approval.

(c) No funds may be expended from the State Fund, General Revenue for any supplemental reimbursement paid under this section.

(d) The nonfederal share of the supplemental reimbursement submitted to the federal Centers for Medicare and Medicaid Services for purposes of claiming federal financial participation may be paid only with funds from the governmental entities.

(e) Participation in the program by an eligible provider described in this section is voluntary.

(f) If an applicable governmental entity elects to seek supplemental reimbursement pursuant to this section on behalf of an eligible provider, the governmental entity shall:

(1) Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for the ground emergency medical transportation services are eligible for federal financial participation;

(2) Provide evidence supporting the certification as specified by the department;

(3) Submit data as specified by the department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation; and

(4) Keep, maintain, and have readily retrievable any records specified by the department to fully disclose reimbursement amounts to which the eligible provider is entitled, and any other records required by the federal Centers for Medicare and Medicaid Services.

(g) (1) The department shall promptly seek any necessary federal approvals for the implementation of this section. The department may limit the program to those costs that are allowable expenditures under Title XIX of the federal Social Security Act (42 U.S.C. §1396 *et seq*.). If federal approval is not obtained for implementation of this section, this section may not be implemented.

(2) The department shall submit claims for federal financial participation for the expenditures for the services that are allowable expenditures under federal law.

(3) The department shall, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

(4) Notwithstanding the provisions of §9-5-26(g)(1) of this code, the department shall, prior to seeking federal approval of any supplemental reimbursement pursuant to this section, attempt to maximize the number of qualified group emergency medical transportation service providers eligible to receive the supplemental reimbursement. These emergency medical transportation service providers would include:

(A) Any not-for-profit emergency medical transport providers not owned by the state or a city, a county, or a city and county;

(B) Any voluntary emergency transportation service providers not owned by the state or a city, a county, or a city and county; and

(C) All other emergency medical transportation service providers licensed pursuant to the provisions of §16-4C-1 *et seq*. of this code.

§9-5-27. Transitioning foster care into managed care.

(a) “Eligible services” means acute care, including medical, pharmacy, dental, and behavioral health services.

(b) The secretary shall transition to a capitated Medicaid program for a child classified as a foster child and a child placed in foster care under Title IV-E of the Social Security Act who is living in the state by January 1, 2020. The program shall be statewide, fully integrated, and risk based; shall integrate Medicaid-reimbursed eligible services; and shall align incentives to ensure the appropriate care is delivered in the most appropriate place and time.

(c) The secretary shall make payments for the eligible services, including home and community-based services, using a managed care model.

(d) The secretary shall submit, if necessary, applications to the United States Department of Health and Human Services for waivers of federal Medicaid requirements that would otherwise be violated in the implementation of the program and shall consolidate any additional waivers where appropriate: *Provided*, That this subsection does not apply to the Aged and Disabled Waiver, the Intellectual/Developmental Disabilities Waiver, and the Traumatic Brain Injury Waiver.

(e) If a selected managed care organization ceases to contract to provide Medicaid managed care services, it must provide all patient records, including medical records, to the next selected managed care organization to ensure the Eligible Medicaid Beneficiaries do not experience an interruption in care.

(f) In designing the program, the secretary shall ensure that the program:

(1) Reduces fragmentation and offers a seamless approach to meeting participants’ needs;

(2) Delivers needed supports and services in the most integrated, appropriate, and cost-effective way possible;

(3) Offers a continuum of acute care services, which includes an array of home and community-based options; and

(4) Includes a comprehensive quality approach across the entire continuum of care services;

(g) An employee of the department who, as a function of that employment, has engaged in the development of any contract developed pursuant to the requirements of this section may not for a period of two years thereafter be employed by any agency or company that has benefitted or stands to benefit directly from a contract between the department and that agency or company.

(h) Any managed care company selected as the managed care contractor pursuant to the

provisions of this article shall have at least 80 percent of the total full-time equivalent positions allocated to manage care of foster children in West Virginia according to the contract must have a primary workplace in the state of West Virginia.

§9-5-28. Requirement for telehealth rates.

The Medicaid plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service at a rate negotiated between the provider and the insurance company for virtual telehealth encounters. The Medicaid plan, which issues, renews, amends, or adjusts a plan, policy, contract, or agreement on or after July 1, 2021, shall provide reimbursement for a telehealth service for an established patient, or care rendered on a consulting basis to a patient located in an acute care facility whether inpatient or outpatient on the same basis and at the same rate under a contract, plan, agreement, or policy as if the service is provided through an in-person encounter rather than provided via telehealth.

§9-5-29. Department of Human Services to develop outcome measures for substance use disorder; develop a quality withhold program; and develop and implement plan for day one enrollment of Medicaid enrollees.

(a) For purposes of this section:

"Department" means the Department of Human Services.

"Managed care organizations" means a certified health maintenance organization (HMO) that provides health care services to Medicaid members pursuant to an agreement or contract with the Bureau for Medical Services.

“Quality withhold” means, in a capitated model, having a portion of a rate withheld subject to performance consistent with established quality requirements.

(b) The department, shall develop performance outcome measures to be implemented at the provider level for substance use disorder in-patient providers. These provider-level outcome measures will include, but not be limited to, nationally recognized measures of performance outcomes related to substance use disorder in-patient care. The Department will utilize national standards from Hedis and/or Atlas, as well as other standardized measures, in developing the provider-level outcome measures and will obtain input from the West Virginia Behavioral Healthcare Providers Association and West Virginia Association of Addiction and Prevention Professionals. The measures will be reported to the Legislative Oversight Commission on Health and Human Resources Accountability on or before August 30, 2024, and will be implemented no later than January 1, 2025, from the initial baseline. These measures shall be shared with the managed care organizations to inform contracting decisions.

(c) The department, shall develop a managed care quality withhold program based upon nationally recognized measures of performance outcomes, including those related to substance use disorder in-patient care. These measures will be reported to the Legislative Oversight Commission on Health and Human Resources Accountability on or before May 30, 2024, and implemented for baseline July 1, 2024. The baseline year will be to establish new entrant into the market. The capitation withhold will begin July 1, 2025.

(d) The department, shall plan for automatic day one enrollment to a managed care organization for all Medicaid enrollees who are eligible for managed care. This workplan shall be presented to the Legislative Oversight Commission on Health and Human Resources Accountability on or before September 30, 2024. The workplan will detail the steps to accomplish this goal, the system changes required, the Center for Medicare and Medicaid Service (CMS) authority changes required along with a detailed timeline of milestones, and a projected completion deadline.

§9-5-29a. Prohibition against payments to certain residential substance use disorder facilities; Requirement for licensure and accreditation; and rulemaking.

(a) Effective January 1, 2026, unless otherwise mandated by federal law or regulation, neither the Bureau for Medical Services, nor any managed care organization contracted to provide services on behalf of the bureau, shall reimburse providers for services rendered on or after January 1, 2026, at a residential substance use disorder treatment facility unless:

At the time treatment was rendered, the facility site was actively:

(A) Licensed by the West Virginia Office of Health Facility Licensure and Certification; and

(B) Accredited by the Commission on Accreditation of Rehabilitation Facilities International (CARF), the Joint Commission, or Det Norske Veritas (DNV) to operate an inpatient facility that provides behavioral health services.

(b) No later than October 1, 2025, the Bureau for Medical Services shall make all necessary filings with the Centers for Medicare and Medicaid Services and submit for public comment any changes to its provider manual that are necessary to ensure the ability to enforce the provisions of subsection (a) of this code section.

(c) Residential substance use disorder facilities shall obtain both licensure and accreditation as required by subsection (a) of this section by January 1, 2026. Any residential substance use disorder facility beginning new operations as a result of a lawful change in ownership, or opening a facility at a new site, shall be required to comply with the requirements of this section to be accredited with CARF, the Joint Commission, or DNV, within one year of its start of operations. However, the Office of Health Facility Licensure and Certification licensure requirement in subsection (a) of this section, all other applicable state laws and regulations, and requirements of the bureau required to be eligible for reimbursement for residential substance use disorder services, shall be applicable during this one year period.

(d) All licensed substance abuse treatment beds are subject to the provisions of §16-2D-9(5) of this code.

(e) The Office of the Inspector General shall propose or amend a rule for legislative approval in accordance with the provisions of §29A-3-1 *et seq.* of this code to implement the provisions of this section.

(f) The Bureau for Medical Services shall prepare a report to the Legislative Oversight Commission on Health and Human Resources Accountability on or before December 31, 2030. That report shall provide data on the effectiveness of the provisions of this section.

(g) Effective July 1, 2031, the provisions of this section shall expire and have no further force or effect unless continued by act of the Legislature.

§9-5-30. Certified community behavioral health clinics.

(a) The Bureau for Medical Services shall develop, seek approval of, and implement a Medicaid state plan amendment as necessary and appropriate to effectuate a system of certified community behavioral health clinics (CCBHCs).

(b) The Bureau for Medical Services, in partnership with the Bureau for Behavioral Health, shall establish a state certification system for CCBHCs in accordance with the following requirements:

(1) To the fullest extent practicable, the CCBHC system shall be consistent with the demonstration program established by Section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93, 42 U.S.C. 1396a note), as amended.

(2) Standards and methodologies for a prospective payment system shall be established to reimburse each CCBHC under the state Medicaid program on a predetermined, fixed amount per day for covered services rendered to each Medicaid beneficiary.

(3) A quality incentive payment system shall be established for those CCBHCs which achieve specific thresholds on performance metrics identified by the Bureau for Medical Services. Such quality incentive payments shall be in addition to the bundled prospective daily rate.

(4) The prospective payment rate for each CCBHC shall be adjusted tri-annually by the Medicare Economic Index as defined in Section 223 of Protecting Access to Medicare Act of 2014. In addition, the prospective payment rate shall allow for modifications based upon a change in scope for an individual CCBHC. Rate adjustments can be made upon request by the provider.

(5) Criteria shall be established to certify a facility as a CCBHC which, at a minimum, shall require each CCBHC to offer directly, or indirectly through formal referral relationships with other providers, the following services:

(A) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;

(B) Screening, assessment, and diagnosis, including risk assessment;

(C) Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;

(D) Outpatient clinic primary care screening and monitoring of key health indicators and health risk;

(E) Targeted case management;

(F) Psychiatric rehabilitation services;

(G) Peer support and counselor services;

(H) Family support services; and

(I) Community-based mental health services, including mental health services for members of the armed forces and veterans.

(c) All nonprofit comprehensive community mental health centers, comprehensive intellectual disability facilities, as established by §27-2A-1 of this code, and all other providers set forth in the Medicaid state plan amendment shall be eligible to apply for certification as a CCBHC.

(d) The Bureau for Medical Services, in partnership with the Bureau for Behavioral Health, shall establish any other procedures and standards as may be necessary for an eligible facility to apply for certification, become certified, and remain certified as a CCBHC, as set forth in the legislative rule developed pursuant to this section.

(e) The participation of any eligible facility in the CCBHC system shall be strictly voluntary. Nothing in this section shall require a facility that is eligible for certification as a CCBHC to apply for such certification.

§9-5-31. Commissioner to conduct study.

(a) The Commissioner of the Bureau for Behavioral Health shall engage the following stakeholders: Behavioral health providers, substance use disorder providers, municipal leaders, and county government leaders to study a breakdown of homeless demographic information throughout West Virginia. The study shall be responsible for:

(1) Presenting a breakdown of homeless demographic information throughout West Virginia and regionally;

(2) Quantifying and inventorying of homelessness resources by region;

(3) Conducting an epidemiological analysis of homeless populations in West Virginia;

(4) Identifying key metrics to measure homelessness across West Virginia in a more consistent manner;

(5) Conducting analysis of whether West Virginia's homeless populations concentrate in certain counties or municipalities and any reasons for such population concentrations;

(6) Determining if state policies cause the state's homeless population to relocate to certain counties or municipalities;

(7) Determining the percentage of homeless individuals that lived in another state or jurisdiction in the past three years or are from another state or jurisdiction; and

(8) Conducting an analysis of whether any health and human service benefits offered in West Virginia attract populations that are homeless or at risk of homelessness.

(b) On or before July 1, 2024, the commissioner shall submit a report of the findings of the study to the President of the Senate, Speaker of the House of Delegates, and the Joint Committee on Government and Finance for consideration of legislation that may be appropriate relating to the homeless in West Virginia.

§9-5-32. Prior authorization.

(a) As used in this section, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

"Episode of care" means a specific medical problem, condition, or specific illness being managed, including tests, procedures, and rehabilitation initially requested by the health care practitioner, to be performed at the site of service, excluding out-of-network care: *Provided*, That any additional testing or procedures related or unrelated to the specific medial problem, condition, or specific illness being managed may require a separate prior authorization.

"National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard" means the NCPDP SCRIPT Standard Version 201310 or the most recent standard adopted by the United States Department of Health and Human Services. Subsequently released versions may be used provided that the new version is backward compatible with the current version approved by the United States Department of Health and Human Services;

"Prior authorization" means obtaining advance approval from the Bureau for Medical Services about the coverage of a service or medication.

(b) The Bureau for Medical Services shall require prior authorization forms, including any related communication, to be submitted via an electronic portal and shall accept one prior authorization for an episode of care. The portal shall be placed in an easily identifiable and accessible place on the Bureau for Medical Services' webpage and the portal web address shall be included on the insured's insurance card. The portal shall:

(1) Include instructions for the submission of clinical documentation;

(2) Provide an electronic notification to the health care provider confirming receipt of the prior authorization request for forms submitted electronically;

(3) Contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the Bureau of Medical Services requires a prior authorization. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list shall be updated at least quarterly to ensure that the list remains current;

(4) Inform the patient if the Bureau for Medical Services requires a plan member to use step therapy protocols. This shall be conspicuous on the prior authorization form. If the patient has completed step therapy as required by the Bureau for Medical Services and the step therapy has been unsuccessful, this shall be clearly indicated on the form, including information regarding medication or therapies which were attempted and were unsuccessful; and

(5) Be prepared by July 1, 2024.

(c) Provide electronic communication via the portal regarding the current status of the prior authorization request to the health care provider.

(d) After the health care practitioner submits the request for prior authorization electronically, and all of the information as required is provided, the Bureau of Medical Services shall respond to the prior authorization request within five business days from the day on the electronic receipt of the prior authorization request, except that the Bureau of Medical Services shall respond to the prior authorization request within two business days if the request is for medical care or other service for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following:

(1) Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state; or

(2) In the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

(e) If the information submitted is considered incomplete, the Bureau for Medical Services shall identify all deficiencies, and within two business days from the day on the electronic receipt of the prior authorization request, return the prior authorization to the health care practitioner. The health care practitioner shall provide the additional information requested within three business days from the day the return request is received by the health care practitioner. The Bureau for Medical Services shall render a decision within two business days after receipt of the additional information submitted by the health care provider. If the health care practitioner fails to submit additional information, the prior authorization is considered denied and a new request shall be submitted.

(f) If the Bureau for Medical Services wishes to audit the prior authorization or if the information regarding step therapy is incomplete, the prior authorization may be transferred to the peer review process within two business days from the day on the electronic receipt of the prior authorization request.

(g) A prior authorization approved by the Bureau for Medical Services is carried over to all other managed care organizations and health insurers for three months if the services are provided within the state.

(h) The Bureau for Medical Services shall use national best practice guidelines to evaluate a prior authorization.

(i) If a prior authorization is rejected by the Bureau for Medical Services and the health care practitioner who submitted the prior authorization requests an appeal by peer review of the decision to reject, the peer review shall be with a health care practitioner, similar in specialty, education, and background. The Bureau for Medical Services' medical director has

the ultimate decision regarding the appeal determination and the health care practitioner has the option to consult with the medical director after the peer-to- peer consultation. Time frames regarding this peer-to-peer appeal process shall take no longer than five business days from the date of the request of the peer-to-peer consultation. Time frames regarding the appeal of a decision on a prior authorization shall take no longer than 10 business days from the date of the appeal submission.

(j) (1) Any prescription written for an inpatient at the time of discharge requiring a prior authorization may not be subject to prior authorization requirements and shall be immediately approved for not less than three days: *Provided*, That the cost of the medication does not exceed $5,000 per day and the health care practitioner shall note on the prescription or notify the pharmacy that the prescription is being provided at discharge. After the three-day time frame, a prior authorization shall be obtained.

(2) If the approval of a prior authorization requires a medication substitution, the substituted medication shall be as required under §30-5-1 *et seq*. of this code.

(k) If a health care practitioner has performed an average of 30 procedures per year and in a six-month time period during that year has received a 90 percent final prior approval rating, the Bureau for Medical Services may not require the health care practitioner to submit a prior authorization for at least the next six months or longer if the Bureau for Medical Services allows: *Provided*, That at the end of the six-month time frame, or longer if the Bureau for Medical Services allows, the exemption shall be reviewed prior to renewal. If approved, the renewal shall be granted for a time period equal to the previously granted time period, or longer if the Bureau for Medical Services allows. This exemption is subject to internal auditing at any time by the Bureau for Medical Services and may be rescinded if the Bureau for Medical Services determines the health care practitioner is not performing services or procedures in conformity with the Bureau for Medical Services' benefit plan, it identifies substantial variances in historical utilization or identifies other anomalies based upon the results of the Bureau for Medical Services' internal audit. The Bureau for Medical Services shall provide a health care practitioner with a letter detailing the rationale for revocation of his or her exemption. Nothing in this subsection may be interpreted to prohibit the Bureau for Medical Services from requiring a prior authorization for an experimental treatment, non-covered benefit, pharmaceutical medication, or any out-of-network service or procedure.

(l) This section is effective for policy, contract, plans, or agreements beginning on or after January 1, 2024. This section applies to all policies, contracts, plans, or agreements, subject to this article, that are delivered, executed, issued, amended, adjusted, or renewed in this state on or after the effective date of this section.

(m) The Inspector General shall request data on a quarterly basis, or more often as needed, to oversee compliance with this article. The data shall include, but not be limited to, prior authorizations requested by health care providers, the total number of prior authorizations denied broken down by health care provider, the total number of prior authorizations

appealed by health care providers, the total number of prior authorizations approved after appeal by health care providers, the name of each gold card status physician, and the name of each physician whose gold card status was revoked and the reason for revocation.

(n) The Inspector General may assess a civil penalty for a violation of this section.

§9-5-33. Managed care organization contracts exempt from purchasing requirements; providing for exceptions.

(a) Notwithstanding any other provision to the contrary, the Bureau for Medical Services is exempt from all requirements of the Purchasing Division, authorized under §5A-3-1 *et seq*. of this code, with respect to managed care contracts: Provided, That for purposes of continuity of care, the Bureau for Medical Services may not:

(1) Disrupt existing WV Medicaid and WV Children's Health Insurance Plan enrollment within an existing managed care organization as part of any such purchasing exemption; or

(2) Redistribute or reassign membership of an existing managed care organization to any new, qualifying managed care entrant as part of any contract awarded pursuant to such exemption.

The Bureau for Medical Services shall integrate any and all new and qualifying managed care entrants into the state's auto-assignment logic for new members and shall publicize any eligible managed care organization for purposes of self-selection by the member. No plan shall have preferential assignment of new members and each plan will be assigned equally.

(b) The Bureau for Medical Services is not exempt from the requirements of the Purchasing Division, authorized under §5A-3-1 *et seq*. of this code, when soliciting a procurement for specialized populations, to include, but not be limited to, foster care.

§9-5-34. Medicaid pharmacy benefit management; prohibited contracting; pharmacy cost containment tool.

(a) For purposes of this section, "pharmacy benefit manager" and "affiliate" have the meanings ascribed to those terms in §33-51-3 of this code.

(b) To the extent that Medicaid has a pharmacy benefit manager managing its pharmacy contract, that pharmacy benefit manager may not reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the amount the pharmacy benefit manager reimburses itself or an affiliate for the same prescription drug or pharmacy service.

(c) By July 1, 2026, the Medicaid program shall establish a one-year pilot program to implement a pharmacy cost containment vendor. This pilot program shall focus on actively engaging prescribing providers by presenting information regarding cost and effectiveness, including but not limited to, data on lowest net cost pharmaceutical options and clinically appropriate polypharmacy reduction strategies. This pilot program will not require Medicaid to alter or violate any terms of any existing contractual agreements.

(1) Participation in the pilot program does not mandate changes in clinical practice, as prescribing providers engaged by the vendor retain clinical discretion and are not required to modify prescribing patterns based on information presented. The vendor managing this service shall be separate and distinct from any pharmacy benefit management contract that any state agency may have in the management of the pharmacy benefit.

(2) The state expenditure on the pilot program may not increase relative to the protected savings generated from the pilot program. Any cost containment vendor utilized by Medicaid under this pilot program must agree to the terms that reflect contractual savings to fee guarantee.

(3) Prescribing providers engaged by the vendor are not required to modify their prescribing based on the information presented pursuant to this subsection.

(4) If the pilot program determines a net savings, Medicaid may enter into a contractual arrangement with the vendor prior to the conclusion of the pilot program to ensure long term savings are achieved.