WEST VIRGINIA CODE CHAPTER 9

§9-1-1. Legislative purpose.

[Repealed.]

§9-1-2. Definitions.

The following words and terms when used in this chapter have the meanings indicated:

"Department" means the Department of Human Services.

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

"Federal-state assistance" means and includes: (1) All forms of aid, care, assistance and services to or on behalf of persons, which are authorized by, and who are authorized to receive the same under and by virtue of, subchapters one, four, five, ten, fourteen, sixteen, eighteen and nineteen, chapter seven, Title 42, United States Code, as those subchapters have heretofore been and may hereafter be amended, supplemented and revised by acts of Congress, and as those subchapters so amended, supplemented and revised have heretofore been and may hereafter be supplemented by valid rules and regulations promulgated by authorized federal agents and agencies, and as those subchapters so amended, supplemented and revised have heretofore been and may hereafter be supplemented by rules promulgated by the state division of human services or by the Department of Human Services, which rules shall be consistent with federal laws, rules and regulations, but not inconsistent with state law; and (2) all forms of aid, care, assistance and services to persons, which are authorized by, and who are authorized to receive the same under and by virtue of, any act of Congress, other than the federal social security act, as amended, for distribution through the state division of human services or the Department of Human Services to recipients of any form of aid, care, assistance and services to persons designated or referred to in (1) of this definition and to recipients of state assistance, including by way of illustration, surplus food and food stamps, which Congress has authorized the secretary of agriculture of the United States to distribute to needy persons.

"Federal assistance" means and includes all forms of aid, care, assistance and services to or on behalf of persons, which are authorized by, and who are authorized to receive the same under and by virtue of, any act of Congress for distribution through the state division of human services or the Department of Human Services, the cost of which is paid entirely out of federal appropriations.

"State assistance" means and includes all forms of aid, care, assistance, services and general relief made possible solely out of state, county and private appropriations to or on behalf of indigent persons, which are authorized by, and who are authorized to receive the same under and by virtue of, state division of human services' or Department of Human Services' rules.

"Assistance" means the three classes of assistance, namely: Federal-state assistance, federal assistance and state assistance.

"Indigent person" means any person who is domiciled in this state and who is actually in need as defined by division or department rules and has not sufficient income or other

resources to provide for such need as determined by the state division of human services or the Department of Human Services.

"Domiciled in this state" means being physically present in West Virginia accompanied by an intention to remain in West Virginia for an indefinite period of time, and to make West Virginia his or her permanent home. The Department of Human Services may by rules supplement the foregoing definition of the term "domiciled in this state", but not in a manner as would be inconsistent with federal laws, rules, and regulations applicable to and governing federal-state assistance.

"Medical services" means medical, surgical, dental and nursing services, and other remedial services recognized by law, in the home, office, hospital, clinic and any other suitable place, provided or prescribed by persons permitted or authorized by law to give such services; the services to include drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic services, nursing home and convalescent care and such other medical services and supplies as may be prescribed by the persons.

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

"Estate" means all real and personal property and other assets included within the individual's estate as defined in the state's probate law.

"Services" means nursing facility services, home and community-based services, and related hospital and prescription drug services for which an individual received Medicaid medical assistance.

"State Medicaid agency" means the Bureau for Medical Services that is the federally designated single state agency charged with administration and supervision of the state Medicaid program.

§9-2-1. Department of Human Services.

Until January 1, 2024, the division of human services within the Department of Health and Human Resources shall have those powers and duties respecting the administration of the assistance programs as authorized, granted and imposed by this chapter and elsewhere by law. Beginning January 1, 2024, the Department of Human Services is comprised of the agencies as provided in §5F-2-1a of this code, is charged with the administration of this chapter, and shall have those powers and duties respecting the administration of the assistance programs as authorized, granted and imposed by this chapter and elsewhere by law.

§9-2-1a. Department of Health and Human Resources.

[Repealed.]

§9-2-2. Secretary to be administrative head of department; appointment; not to hold other office or engage in political activity.

The Secretary of the Department of Human Services is the chief executive officer of that department and beginning January 1, 2024, is charged with the administration of this chapter. The Governor shall appoint the secretary, by and with the advice and consent of the Senate, for the term for which the Governor is elected, and the secretary shall serve at the will and pleasure of the Governor. The Secretary shall be paid an annual salary not to exceed $175,000. Upon his or her initial appointment, which may be at any time after the effective date of this act, the Secretary shall take the oath of office described in this section and commence his or her duties. If appointed before January 1, 2024, the Secretary shall take the oath of office described in this section and commence such duties as determined by the Secretary to be necessary to prepare for the administration of this chapter.

Before entering upon the duties of his or her office, the secretary shall take and subscribe to the oath of office prescribed by section five, article four of the state Constitution.

The secretary shall not be a candidate for, or hold, any other public office or public employment under the federal government or under the government of this state or any of its political subdivisions, or be a member or officer of any political party committee, or serve as an election official, or engage in any political activity, other than to vote, in behalf of, or in opposition to, any candidate, political party or public issue involved in an election. Any violation by the secretary of the provisions of this section shall automatically vacate his or her appointment as secretary.

§9-2-3. Acceptance of federal-state assistance and federal assistance.

The state assents to the purposes of federal-state assistance and federal assistance, accepts federal appropriations and other forms of assistance made under or pursuant thereto, and authorizes the receipt of such appropriations into the state Treasury and the receipt of other forms of assistance by the department for expenditure, disbursement, and distribution by the department in accordance with the provisions of this chapter and the conditions imposed by applicable federal laws, rules and regulations.

§9-2-3a. Authorized exemption from federal law; exceptions.

Pursuant to the authority and option granted by 21 U.S.C. §862a(d)(1)(A) to the states, West Virginia exempts all individuals domiciled within the state from the application of 21 U.S.C. §862a(a)(2) unless the offense of conviction has as an element thereof misuse of supplemental nutrition assistance program benefits, loss of life, or the causing of physical injury.

§9-2-4. Organization of department of welfare.

Within limits of state appropriations and federal grants and subject to provisions of state and federal laws, rules and regulations, the commissioner shall organize the department into such offices, divisions, agencies and other administrative units, and, consistent with the requirements of article six, chapter twenty-nine of this code, shall appoint and employ for the department such deputies, assistants and employees, as may in his judgment be necessary or desirable to carry out fully and in an orderly, efficient and economical manner the powers, duties and responsibilities of the department and of his office.

§9-2-5. Administering the state assistance programs; information and data to be supplied by other agencies.

(a) The department shall administer the state assistance programs, for which responsibility it shall have:

(1) All powers, not inconsistent with state law, as may be necessary for this state to obtain maximum federal funds made available for federal-state assistance within whatever limits or restrictions may be imposed by, or may exist by reason of the amount of state funds appropriated for the assistance; and

(2) All powers, not inconsistent with state law, as may be necessary for the disbursement and distribution of assistance in as prompt, fair, orderly, efficient and economical manner as possible.

(b) Notwithstanding any other provision of this code to the contrary, each, agency, commission or board of state government shall make available to the department information and data it collects about any applicant for or recipient of any type assistance to determine if an applicant or recipient is qualified or eligible for any such assistance.

§9-2-6. Secretary of Department of Human Services; powers and duties.

In addition to the authority provided in §5F-2-2 of this code, the secretary shall:

(1) Coordinate efforts with the Secretary of Health and the Secretary of Health Facilities, including authority to share the expense of administrative services through a memorandum of understanding established by agreement of the secretaries as required under §5F-2-1a of this code;

(2) Promulgate, amend, revise, and rescind legislative rules and policies respecting qualifications for receiving assistance consistent with or permitted by federal laws, rules, and policies, but not inconsistent with state law: *Provided*, That rules and policies respecting qualifications shall permit the expenditure of state funds to pay for care rendered in any birthing center licensed under the provisions of §16-2E-1 *et seq*. of this code by a licensed nurse midwife or midwife as this occupation is defined in §30-15-7 of this code and which care is within the scope of duties for such licensed nurse midwife or midwife as permitted by §30-15-7 of this code;

(3) Obtain by purchase or lease grounds, buildings, office, or other space, equipment, facilities, and services as may be necessary for the execution and administration of the secretary's powers: *Provided*, That the provisions of §5A-10-1 *et seq*. of this code are followed;

(4) Contract with the federal government or its agencies, other states, political subdivisions of this state, corporations, associations, partnerships, or individuals: *Provided*, That the provisions of §5A-3-1 *et seq*. of this code are followed;

(5) Contract to implement professional health care, managed care, actuarial and health care-related monitoring, quality review/utilization, claims processing, and independent professional consultant contracts for the Medicaid program: *Provided*, That the provisions of §5A-3-1 *et seq*. of this code are followed.

(6) Accept gifts or grants, whether in money, land, services, or materials, which gift or gifts, if in the form of moneys, shall be placed in a separate fund and expended solely for the purpose of public assistance programs. No part of this special fund may revert to the general revenue funds of this state. No expenses incurred pursuant to this special fund may be a charge against the general funds of this state;

(7) Establish within the department an Office of Inspector General for the purpose of conducting and supervising investigations, performing inspections, evaluations, and review, and providing quality control for the programs of the department. The Office of Inspector General shall be headed by the Inspector General who shall report directly to the secretary. Neither the secretary nor any employee of the department may prevent, inhibit, or prohibit the Inspector General or his or her employees from initiating, carrying out, or completing any investigation, inspection, evaluation, review, or other activity oversight of public

integrity by the Office of the Inspector General. The secretary shall place within the Office of Inspector General any function he or she deems necessary. Qualification, compensation, and personnel practice relating to the employees of the Office of the Inspector General, including that of the position of Inspector General, shall be governed by the classified service provisions of §29-6-1 *et seq*. of this code and rules promulgated thereunder. The Inspector General shall supervise all personnel of the Office of Inspector General: *Provided*, That beginning January 1, 2024, the provisions of this subdivision expire and shall be superseded by the provisions of §16-1-22 of this code.

(8) Provide at department expense a program of continuing professional, technical, and specialized instruction for the personnel of the department;

(9) Pay from available funds all or part of the reasonable expenses incurred by a person newly employed by the department in moving his household furniture, effects, and immediate family from his or her place of residence in this state to his or her place of employment in this state; and to pay from available funds all or part of the reasonable expenses incurred by a department employee in moving his or her household furniture, effects, and immediate family as a result of a reassignment of the employee which is considered desirable, advantageous to and in the best interests of the state, but no part of the moving expenses of any one such employee may be paid more frequently than once in 12 months or for any movement other than from one place of employment in this state to another place of employment in this state;

(10) Establish a program to provide reimbursement to employees of the department whose items of personal property, as defined by the department by policy, are damaged during the course of employment or other work-related activity as a result of aggressive behavior by a client or patient receiving services from the department: *Provided*, That the reimbursement is limited to a maximum amount of $250 per claim;

(11) Prepare and submit state plans which will meet the requirements of federal laws, rules governing federal-state assistance, and federal assistance, and which are not inconsistent with state law;

(12) Organize within the department a board of review, consisting of a chairman appointed by the secretary and as many assistants or employees of the department as may be determined by the secretary and as may be required by federal laws and rules respecting state assistance, federal-state assistance, and federal assistance, the board of review to have such powers of a shall review nature and such additional powers as may be granted to it by the secretary and as may be required by federal laws and rules respecting federal-state assistance and federal assistance: *Provided*, That beginning January 1, 2024, the provisions of this subdivision expire and shall be superseded by the provisions of §16-1-22 of this code.

(13) Provide by rules, review and appeal procedures within the department of Health and Human Resources as may be required by applicable federal laws and rules respecting state assistance, federal-state assistance, and federal assistance, and as will provide applicants

for, and recipients of, all classes of welfare assistance an opportunity to be heard by the board of review, a member thereof, or individuals designated by the board, upon claims involving denial, reduction, closure, delay, or other action or inaction pertaining to public assistance: *Provided*, That beginning January 1, 2024, the provisions of this subdivision expire and shall be superseded by the provisions of §16-1-22 of this code.

(14) Provide by rules, consistent with requirements of applicable federal laws and rules, application forms and application procedures for public assistance;

(15) Provide locations for making applications for public assistance;

(16) Provide a citizen or group of citizens an opportunity to file objections and to be heard upon objections to the grant of public assistance;

(17) Delegate to the personnel of the department all powers and duties vested in the secretary;

(18) Make reports as may be required by applicable federal laws and rules respecting assistance;

(19) Invoke any legal, equitable, or special remedies for the enforcement of the provisions of this chapter;

(20) Require a provider, subgrantee, or other entity performing services on behalf of the department to comply with all applicable laws, rules, and written procedures pertaining to the program for which the entity is providing or coordinating services, including, but not limited to, policy manuals, statements of work, program instructions, or other similar agreements. When submitting a claim for payment, the entity shall certify that it has complied with all material conditions for payment. Knowingly and intentionally submitting a claim or billing for services performed in material violation of any law, rule, policy, or other written agreement shall constitute fraud and the agreement for provision of services shall terminate. The entity shall be required to repay the department for any payment under the program for which the provider was not entitled, regardless of whether the incorrect payment was the result of department error, fraud, or other cause. A demand for repayment or termination of agreement for provision of services shall be subject to the due process procedures pursuant to §29A-5-1 *et seq*. of this code. The provisions of this subdivision do not apply to fraud in the Medicaid program;

(21) Develop a data analytics pilot program to identify potential fraud and help guide policy objectives to eliminate future fraud;

(22) Cooperate with the Office of the Inspector General and take action on its findings; and

(23) Annually allocate Child Protective Services workers by districts of the Bureau for Social Services and report the allocation process to the Legislative Oversight Commission on Health and Human Resources Accountability by July 1 each year.

§9-2-6a. Secretary to develop caseload standards; committee; definitions.

The secretary shall develop caseload standards based on the actual duties of employees in each program area of the department and may take into consideration existing professional caseload standards. Standards shall be reasonable and achievable.

A caseload standards committee shall be established and composed of two employees from each program area in each region. The members shall be elected by the employees from each program area from among all the employees in the program area. A subcommittee composed of the members from each program of services provided shall meet with the appropriate office director to develop caseload standards for each program. The committee shall meet at least twice yearly and shall report recommendations to the commissioner through the personnel advisory committee representative under existing procedures.

Representatives of an employee organization may serve in an advisory role.

The caseload standards which are developed establishing minimum and maximum caseloads shall be advisory for the department in the hiring of staff and in individual caseload assignments, and may be used as a basis of the Department of Human Services personal services budget request to the governor and the Legislature.

As used in this section:

"Caseload standards" means a measurable numerical minimum and maximum workload which an employee can reasonably be expected to perform in a normal workday or workweek, based on the number, variety and complexity of cases handled or number of different job functions performed.

"Professional caseload standards" means standards established by national standard setting authorities, when they exist, or caseload standards used in other states which have similar job titles.

§9-2-7. State's participation in federal work incentive program.

The state of West Virginia hereby acknowledges that the Congress of the United States has enacted legislation amending the Social Security Act to permit states to establish work incentive programs. The commissioner is hereby authorized to transfer moneys from any appropriate public assistance grant account under his control to the special fund, administered by the United States secretary of labor, created by such amendments. Any moneys transferred by the commissioner to the aforesaid special fund shall be considered as money expended for welfare grants. The commissioner is further empowered to promulgate rules, establish plans and perform any other acts necessary to implement this state's participation in the aforesaid work incentive program.

The commissioner is directed and authorized to cooperate and coordinate his activities in regard to such program with the commissioner of the West Virginia department of employment security as contemplated by section sixteen-a, article two, chapter twenty-one-a of the Code of West Virginia.

§9-2-8. Information and referral services.

(a) Each local human services office shall compile, maintain and post a current list of donated food banks and other emergency food providers in the area served by the local food stamp office and refer individuals who need food to local programs that may be able to provide assistance.

(b) The department shall use its existing statewide toll free telephone number to provide emergency food information and to refer needy individuals to local programs that may be able to provide assistance. The department shall publish the telephone number for referrals in the emergency telephone numbers section of local telephone books. The department shall display this telephone number in all its offices that issue food stamps.

§9-2-9. Secretary to develop Medicaid monitoring and case management.

[Repealed]

§9-2-9a. Agreements between the Secretary and three higher education institutions.

Any contract, agreement or memorandum of understanding between the secretary and West Virginia University, West Virginia School of Osteopathic Medicine or Marshall University for services is exempt from the provisions of §5A-3-1 *et seq*., of this code: *Provided*, That any contract entered into under the provisions of subdivision five, section six of this article, for the provision of Medicaid services by a risk-bearing entity is not exempt from the provisions of §5A-3-1 *et seq*., of this code.

§9-2-9b.

Repealed.

Acts, 2013 Reg. Sess., Ch. 100.

§9-2-9c. Behavioral Mental Health Services Fund created.

There is created in the State Treasury a special revenue account to be designated the "Behavioral Mental Health Services Fund" which is an interest-bearing account that may be invested and retain all earnings. On or before August 1, 2010, the State Treasurer shall make a one-time transfer of $14,750,000 from Fund 1509 – Consumer Protection Recovery Fund, administered by the Attorney General, into the Behavioral Mental Health Services Fund. All moneys transferred to this fund shall be expended in accordance with the settlement provisions of State of West Virginia v. Eli Lilly and Company, Inc., United States District Court of the Eastern District of New York, Civil Action No. 06-CV-5826. Nothing in this article may be construed to mandate additional funding or to require any additional appropriation by the Legislature.

§9-2-10. Collection of copayments by health care providers; penalties.

(a) The secretary is directed to institute a program by January 1, 1994, which requires the payment and collection of copayments. Such program shall conform with Section 447.53, Chapter 42 of the Code of Federal Regulations, and the amount of such copayments shall be determined in accordance with the provisions of Sections 447.54 and 447.55, Chapter 42 of the Code of Federal Regulations. The secretary shall complete all federal requirements necessary to implement this section, including the submission of any amendment to the state Medicaid plan, immediately following the effective date of this section.

(b) Any individual or entity receiving reimbursement from this state under the medical assistance program of the Social Security Act is required to collect such copayments: *Provided*, That in accordance with Section 447.15, Chapter 42 of the Code of Federal Regulations, no such individual or entity shall refuse care or services to any Medicaid-eligible individual because that individual is unable to pay such copayment. The amount of copayments collected shall be reported to the secretary.

(c) After February 1, 1994, any person, firm, corporation or other entity who willfully, by means of a false statement or representation, or by concealment of any material fact, or by other fraudulent scheme, device or artifice on behalf of himself, itself or others, fails to attempt to collect copayments as required by this section, shall be liable for payment of a civil money penalty in the amount of $100 for each occurrence of willful failure to collect a required copayment.

(d) If it comes to the attention of the secretary that a person or other entity is failing to attempt to collect copayments as mandated, the matter shall be referred to the Medicaid fraud control unit for investigation and referral for prosecution pursuant to the provisions of article seven of this chapter.

§9-2-11. Limitation on use of funds.

No funds from the Medicaid program accounts may be used to pay for the performance of an abortion unless the abortion is permitted by §16-2R-3 of this code.

§9-2-12. Coverage for patient cost of clinical trials.

(a) The provisions of this section and section twelve-a of this article apply to the health plans regulated by this article.

(b) This section does not apply to a policy, plan or contract paid for under Title XVIII of the Social Security Act.

(c) A policy, plan or contract subject to this section shall provide coverage for patient cost to a member in a clinical trial, as a result of:

(1) Treatment provided for a life-threatening condition; or

(2) Prevention of, early detection of or treatment studies on cancer.

(d) The coverage under subsection (c) of this section is required if:

(1)(A) The treatment is being provided or the studies are being conducted in a Phase II, Phase III or Phase IV clinical trial for cancer and has therapeutic intent; or

(B) The treatment is being provided in a Phase II, Phase III or Phase IV clinical trial for any other life-threatening condition and has therapeutic intent;

(2) The treatment is being provided in a clinical trial approved by:

(A) One of the national institutes of health;

(B) An NIH cooperative group or an NIH center;

(C) The FDA in the form of an investigational new drug application or investigational device exemption;

(D) The federal department of Veterans Affairs; or

(E) An institutional review board of an institution in the state which has a multiple project assurance contract approved by the office of protection from research risks of the national institutes of health;

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;

(4) There is no clearly superior, noninvestigational treatment alternative;

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be more effective than the noninvestigational treatment alternative;

(6) The treatment is provided in this state: Provided, That, if the treatment is provided

outside of this state, the treatment must be approved by the payor designated in subsection (a) of this section;

(7) Reimbursement for treatment is subject to all coinsurance, copayment and deductibles and is otherwise subject to all restrictions and obligations of the health plan; and

(8) Reimbursement for treatment by an out of network or noncontracting provider shall be reimbursed at a rate which is no greater than that provided by an in network or contracting provider. Coverage shall not be required if the out of network or noncontracting provider will not accept this level of reimbursement.

(e) Payment for patient costs for a clinical trial is not required by the provisions of this section, if:

(1) The purpose of the clinical trial is designed to extend the patent of any existing drug, to gain approval or coverage of a metabolite of an existing drug, or to gain approval or coverage relating to additional clinical indications for an existing drug; or

(2) The purpose of the clinical trial is designed to keep a generic version of a drug from becoming available on the market; or

(3) The purpose of the clinical trial is to gain approval of or coverage for a reformulated or repackaged version of an existing drug.

(f) Any provider billing a third party payor for services or products provided to a patient in a clinical trial shall provide written notice to the payor that specifically identifies the services as part of a clinical trial.

(g) Notwithstanding any provision in this section to the contrary, coverage is not required for Phase I of any clinical trial.

§9-2-12a. Definitions.

For purposes of section twelve of this article:

(a) A "clinical trial" is a study that determines whether new drugs, treatments or medical procedures are safe and effective on humans. To determine the efficacy of experimental drugs, treatments or procedures, a study is conducted in four phases including the following:

Phase II: The experimental drug or treatment is given to, or a procedure is performed on, a larger group of people to further measure its effectiveness and safety.

Phase III: Further research is conducted to confirm the effectiveness of the drug, treatment or procedure, to monitor the side effects, to compare commonly used treatments and to collect information on safe use.

Phase IV: After the drug, treatment or medical procedure is marketed, investigators continue testing to determine the effects on various populations and to determine whether there are side effects associated with long-term use.

(b) "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group.

(c) "Cooperative group" includes:

(1) The national cancer institute clinical cooperative group;

(2) The national cancer institute community clinical oncology program;

(3) The AIDS clinical trial group; and

(4) The community programs for clinical research in AIDS.

(d) "FDA" means the federal food and drug administration.

(e) "Life-threatening condition" means that the member has a terminal condition or illness that according to current diagnosis has a high probability of death within two years, even with treatment with an existing generally accepted treatment protocol.

(f) "Member" means a policyholder, subscriber, insured, certificate holder or a covered dependent of a policyholder, subscriber, insured or certificate holder.

(g) "Multiple project assurance contract" means a contract between an institution and the federal department of health and human services that defines the relationship of the institution to the federal department of health and human services and sets out the responsibilities of the institution and the procedures that will be used by the institution to

protect human subjects.

(h) "NIH" means the national institutes of health.

(i) "Patient cost" means the routine costs of a medically necessary health care service that is incurred by a member as a result of the treatment being provided pursuant to the protocols of the clinical trial. Routine costs of a clinical trial include all items or services that are otherwise generally available to beneficiaries of the insurance policies. "Patient cost" does not include:

(1) The cost of the investigational drug or device;

(2) The cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided to the member for purposes of the clinical trial;

(3) Services customarily provided by the research sponsor free of charge for any participant in the trial;

(4) Costs associated with managing the research associated with the clinical trial including, but not limited to, services furnished to satisfy data collection and analysis needs that are not used in the direct clinical management of the participant; or

(5) Costs that would not be covered under the participant's policy, plan, or contract for noninvestigational treatments;

(6) Adverse events during treatment are divided into those that reflect the natural history of the disease, or its progression, and those that are unique in the experimental treatment. Costs for the former are the responsibility of the payor as provided in section two of this article, and costs for the later are the responsibility of the sponsor. The sponsor shall hold harmless any payor for any losses and injuries sustained by any member as a result of his or her participation in the clinical trial.

§9-2-13. Judicial review of decisions of contested cases.

[Repealed.]

§9-3-1. Application for and granting of federal-state or federal assistance.

(a) Any person domiciled in this state, who shall make, or have made in his or her behalf, an application therefor and who is otherwise in all respects qualified to receive the same, shall be granted federal-state assistance or federal assistance in such form and amount, to such extent, and for such period, as authorized by applicable federal and state laws, rules and regulations and as determined by the department in accordance with such laws, rules and regulations and within limits of available funds.

(b) In conjunction with the Higher Education Policy Commission and Workforce West Virginia, the Bureau for Family Assistance must compile and maintain a list of those services available to assist and support individuals who are qualified to receive federal, federal-state, or state assistance and who want to obtain a degree, secure workforce training, or reenter the workforce. This document must be maintained on the Bureau for Family Assistance's website and any hard copy requested for this document must be supplied to the person requesting the information via first-class mail.

§9-3-2. Application for and granting of state assistance.

(a) Any indigent person domiciled in this state, who shall make, or have made in his or her behalf, an application therefor and who is otherwise in all respects qualified to receive the same, shall be granted state assistance in such form and amount, to such extent, and for such period, as authorized by applicable state laws, rules and regulations of the department and as determined by the department in accordance with such laws, rules and regulations and within limits of available funds.

(b) In conjunction with the Higher Education Policy Commission and Workforce West Virginia, the Bureau for Family Assistance must compile and maintain a list of those services available to assist and support individuals who are qualified to receive federal, federal-state, or state assistance and who want to obtain a degree, secure workforce training, or reenter the workforce. This document must be maintained on the Bureau for Family Assistance's website and any hard copy requested for this document must be supplied to the person requesting the information via first-class mail.

§9-3-3. Making application, investigation and grant.

All persons wishing to make application for any class of welfare assistance shall have an opportunity to do so. Upon receipt of an application for any class of welfare assistance, the department shall make such investigation as may be necessary and as the exigency of the case will permit to determine the eligibility of the applicant for, and the form, amount, extent, and period of, such assistance.

When the department approves an application for any class of welfare assistance, it shall fix the amount, form, extent and period of such assistance in accordance with applicable federal and state laws, rules and regulations and within the limits of available funds.

§9-3-4. Assignment of support obligations.

Any recipient of financial assistance under the program of state and federal assistance established by Title IV of the federal Social Security Act of 1965, as amended, or any successor act thereto, shall, as a condition of receiving assistance funded under this part, assign to the Department of Human Services any right the family member may have (on behalf of the family member or of any other person for whom the family member has applied for or is receiving such assistance) to support from any other person, not exceeding the total amount of assistance so paid to the family, which accrues during the period that the family receives assistance under the program.

Each applicant for assistance subject to the assignment established in this section shall (during the application process) be informed in writing of the nature of the assignment.

Any payment of federal and state assistance made to or for the benefit of any child or children or the caretaker of a child or children creates a debt due and owing to the Department of Human Services by the person or persons responsible for the support and maintenance of the child, children or caretaker in an amount equal to the amount of assistance money paid: *Provided*, That the debt is limited by the amount established in any court order or final decree of divorce if the amount in the order or decree is less than the amount of assistance paid.

The assignment under this section shall subrogate the Department of Human Services to the rights of the child, children or caretaker to the prosecution or maintenance of any action or procedure existing under law providing a remedy whereby Department of Human Services may be reimbursed for moneys expended on behalf of the child, children or caretaker. The Department of Human Services shall further be subrogated to the debt created by any order or decree awarding support and maintenance to or for the benefit of any child, children or caretaker included within the assignment under this section and shall be empowered to receive money judgments and endorse any check, draft, note or other negotiable document in payment thereof.

The assignment created under this section shall be released upon closure of the assistance case and the termination of assistance payments except for support and maintenance obligations accrued and owing at the time of closure which are necessary to reimburse the department for any balance of assistance payments made.

The Department of Human Services may, at the election of the recipient, continue to receive support and maintenance moneys on behalf of the recipient following closure of the assistance case and shall distribute the moneys to the caretaker, child or children.

§9-3-5. Services to persons not otherwise eligible.

The department may make available the services established under the provisions of section four of this article, to any person not eligible for receipt of public assistance upon application by such person: *Provided*, That the department may not require such person to use its services. These services may include, but need not be limited to, the following: Location of the responsible parent whose whereabouts are unknown, collection of child support and maintenance moneys owed, and distribution of support and maintenance moneys paid.

The department may charge a reasonable fee to nonpublic assistance persons for the provision of services and, when the department has provided services for the collection of support and maintenance, may charge a reasonable fee to the person responsible for the support and maintenance. The commissioner shall establish by regulations the amount of such fees, not in excess of maximum amounts permitted by applicable federal law, which regulations may be amended and supplemented from time to time.

§9-3-6. Program for drug screening of applicants for cash assistance.

(a) As used in this section:

(1) "Applicant" means a person who is applying for benefits from the Temporary Assistance for Needy Families Program.

(2) "Board of Review" means the board established in §9-2-6(13) of this code.

(3) "Caseworker" means a person employed by the department with responsibility for making a reasonable suspicion determination during the application process for Temporary Assistance for Needy Families Program.

(4) "Child Protective Services" means the agency within the department responsible for investigating reports of child abuse and neglect as required in §49-2-802 of this code.

(5) "Department" means the Department of Human Services.

(6) "Drug screen" or "drug screening" means any analysis regarding substance abuse conducted by the Department of Human Services on applicants for assistance from the Temporary Assistance for Needy Families Program.

(7) "Drug test" or "drug testing" means a drug test which tests urine for amphetamines (amphetamine and methamphetamine) cocaine, marijuana, opiates (codeine and morphine), phencyclidine, barbiturates, benzodiazepines, methadone, propoxyphene, and expanded opiates (oxycodone, hydromorphone, hydrocodone, oxymorphone).

(8) "Secretary" means the secretary of the department or his or her designee.

(9) "Temporary Assistance for Needy Families Program" means assistance provided through ongoing cash benefits pursuant to 42 U. S. C. § 601 *et seq*. operated in West Virginia as the West Virginia Works Program pursuant to §9-9-1 *et seq*. of this code.

(b) Subject to federal approval, the secretary shall implement and administer a program to drug screen any adult applying for assistance from the Temporary Assistance for Needy Families Program. The secretary shall administer this program until December 31, 2026.

(c) Reasonable suspicion exists if:

(1) A case worker determines, based upon the result of the drug screen, that the applicant demonstrates qualities indicative of substance abuse based upon the indicators of the drug screen; or

(2) An applicant has been convicted of a drug-related offense within the three years immediately prior to an application for Temporary Assistance for Needy Families Program and whose conviction becomes known as a result of a drug screen as set forth in this section.

(d) Presentation of a valid prescription for a detected substance that is prescribed by a health care provider authorized to prescribe a controlled substance is an absolute defense for failure of any drug test administered under the provisions of this section.

(e) Upon a determination by the case worker of reasonable suspicion as set forth in this section an applicant shall be required to complete a drug test. The cost of administering the drug test and initial substance abuse testing program is the responsibility of the Department of Human Services. Any applicant whose drug test results are positive may request that the drug test specimen be sent to an alternative drug-testing facility for additional drug testing. Any applicant who requests an additional drug test at an alternative drug-testing facility shall be required to pay the cost of the alternative drug test.

(f) Any applicant who has a positive drug test shall complete a substance abuse treatment and counseling program and a job skills program approved by the secretary. An applicant may continue to receive benefits from the Temporary Assistance for Needy Families Program while participating in the substance abuse treatment and counseling program or job skills program. Upon completion of both a substance abuse treatment and counseling program and a job skills program, the applicant is subject to periodic drug screening and testing as determined by the secretary in rule. Subject to applicable federal laws, any applicant for Temporary Assistance for Needy Families Program who fails to complete, or refuses to participate in, the substance abuse treatment and counseling program or job skills program as required under this subsection is ineligible to receive Temporary Assistance for Needy Families benefits until he or she is successfully enrolled in substance abuse treatment and counseling and job skills programs. Upon a second positive drug test, an applicant shall be ordered to complete a second substance abuse treatment and counseling program and job skills program. He or she shall be suspended from the Temporary Assistance for Needy Families Program for a period of 12 months, or until he or she completes both a substance abuse treatment and counseling program and a job skills program. Upon a third positive drug test an applicant shall be permanently terminated from the Temporary Assistance for Needy Families Program subject to applicable federal law.

(g) Any applicant who refuses a drug screen or a drug test is ineligible for assistance.

(h) The secretary shall order an investigation and home visit from Child Protective Services on any applicant whose benefits are suspended and who has not designated a protective payee or whose benefits are terminated due to failure to pass a drug test. This investigation and home visit may include a face-to-face interview with the child, if appropriate; the development of a protection plan; and, if necessary for the health and well-being of the child, may also involve law enforcement. This investigation and home visit shall be followed by a report detailing recommended action which Child Protective Services shall undertake. Child Protective Services is responsible for providing, directing, or coordinating the appropriate and timely delivery of services to any child who is the subject of any investigation and home visit conducted pursuant to this section. In cases where Child Protective Services determines that the best interests of the child require court action, it shall initiate the appropriate legal proceeding.

(i) Any other adult members of a household that includes a person declared ineligible for the Temporary Assistance for Needy Families Program pursuant to this section shall, if otherwise eligible, continue to receive Temporary Assistance for Needy Families benefits.

(j)(1) No dependent child's eligibility for benefits under the Temporary Assistance for Needy Families Program may be affected by a parent's failure to pass a drug test.

(2) If pursuant to this section a parent is deemed ineligible for the Temporary Assistance for Needy Families Program, the dependent child's eligibility is not affected and an appropriate protective payee shall be designated to receive benefits on behalf of the child.

(3) The parent may choose to designate another person as a protective payee to receive benefits for the minor child. The designated person shall be an immediate family member, or if an immediate family member is not available or declines the option, another person may be designated.

(4) The secretary shall screen and approve the designated person.

(k)(1) An applicant who is determined by the secretary to be ineligible to receive benefits pursuant to subsection (f) of this section due to a failure to participate in a substance abuse treatment and counseling program or a job skills program who can later document successful completion of a drug treatment program approved by the secretary may reapply for benefits six months after the completion of the substance abuse treatment and counseling program or job skills program. An applicant who has met the requirements of this subdivision and reapplies is also required to submit to a drug test and is subject to the provisions of subsection (f) of this section.

(2) An applicant may reapply only once pursuant to the exceptions contained in this subsection.

(3) The cost of any drug screen or test and drug treatment provided under this subsection is the responsibility of the individual being screened and receiving treatment.

(l) An applicant who is denied assistance under this section may request a review of the denial by the Board of Review. The results of a drug screen or test are admissible without further authentication or qualification in the review of denial by the Board of Review and in any appeal. The Board of Review shall provide a fair, impartial, and expeditious grievance and appeal process to applicants who have been denied Temporary Assistance for Needy Families benefits pursuant to the provisions of this section. The Board of Review shall make findings regarding the denial of benefits and issue a decision which either verifies the denial or reverses the decision to deny benefits. Any applicant adversely affected or aggrieved by a final decision or order of the Board of Review may seek judicial review of that decision.

(m) The secretary shall ensure the confidentiality of all drug screen and drug test results administered as part of this program. Drug screen and test results shall be used only for the

purpose of determining eligibility for the Temporary Assistance for Needy Families Program. At no time may drug screen or test results be released to any public or private person or entity or any law-enforcement agency, except as otherwise authorized by this section.

(n) The secretary shall promulgate emergency rules pursuant to the provisions of §29A-3-1 *et seq*. of this code to prescribe the design, operation, and standards for the implementation of this section.

(o) A person who intentionally misrepresents any material fact in an application filed under the provisions of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than $100 nor more than $1,000 or by confinement in jail not to exceed six months, or by both fine and confinement.

(p) The secretary shall report to the Joint Committee on Government and Finance by December 31, 2016, and annually after that until the conclusion of the program on the status of the federal approval and program described in this section. The report shall include, but is not limited to:

(1) The total number of applicants who were deemed ineligible to receive benefits under the program due to a positive drug test for controlled substances;

(2) The number of applicants for whom there was a reasonable suspicion due to a conviction of a drug-related offense within the five years prior to an application for assistance;

(3) The number of those applicants that receive benefits after successful completion of a drug treatment program as specified in this section; and

(4) The total cost to operate the program.

(q) Should federal approval not be given for any portion of the program as set forth in this section, the secretary shall implement the program to meet the federal objections and continue to operate a program consistent with the purposes of this section.

(r) For the purposes of the program contained in this section, pursuant to the authority and option granted by 21 U. S. C. § 862a(d)(1)(A) to the states, West Virginia exempts all persons domiciled within the state from the application of 21 U. S. C. § 862a(a).

§9-4-1.

Repealed.

Acts, 2005 Reg. Sess., Ch. 120.

§9-4-2. Medical services fund.

The special fund known as the State of West Virginia public assistance medical services fund established by chapter one hundred forty-three, acts of the Legislature, regular session, one thousand nine hundred fifty-three, as amended by chapter two, acts of the Legislature, first extraordinary session, one thousand nine hundred sixty, and chapter forty-nine, acts of the Legislature, regular session, one thousand nine hundred sixty-six, shall be continued in accordance with the provisions of this section so long as the same may be required by federal laws, rules and regulations applicable to federal-state assistance and thereafter so long as the commissioner shall deem such fund to be otherwise necessary or desirable, and henceforth such special fund shall be known as the department of human services medical services fund, hereinafter referred to as the fund.

The fund shall consist of payments made into the fund out of state appropriations for medical services to recipients of specified classes of welfare assistance and such federal grants-in-aid as are made available for specified classes of welfare assistance. Any balance in the fund at the end of any fiscal year shall remain in the fund and shall not expire or revert. Payments shall be made out of the fund upon requisition of the commissioner by means of a warrant signed by the Auditor and treasurer.

Recipients of those classes of welfare assistance as are specified by the department, consistent with applicable federal laws, rules and regulations, shall be entitled to have costs of necessary medical services paid out of the fund, in the manner and amounts, to the extent, and for the period determined from time to time to be feasible by the commissioner pursuant to rules, regulations and standards established by him. Such rules, regulations and standards shall comply with requirements of applicable federal laws, rules and regulations and shall be established on the basis of money available for the purpose, the number of recipients, the experience with respect to the incidence of illness, disease, accidents, and other causes among such recipients causing them to require medical services and the costs thereof, the amounts which recipients require otherwise in order to maintain a subsistence compatible with decency and health, and any other factor considered relevant and proper by the commissioner: Provided, That such rules and regulations respecting qualifications shall permit the expenditure of state funds to pay for care rendered in any birthing center licensed under the provisions of article two-e, chapter sixteen of this code, by a licensed nurse midwife or midwife as this occupation is defined in section one, article fifteen, chapter thirty of this code, and which care is within the scope of duties for such licensed nurse midwife or midwife as permitted by the provisions of section seven, article fifteen of said chapter thirty.

§9-4-3. Advisory council.

(a) The advisory council, created by chapter one hundred forty-three, Acts of the Legislature, regular session, 1953, as an advisory body to the state Medicaid Agency with respect to the medical services fund and disbursements therefrom and to advise about health and medical services, is continued so long as the medical services fund remains in existence, and thereafter so long as the state Medicaid Agency considers the advisory council to be necessary or desirable, and it is organized as provided by this section and applicable federal law and has those advisory powers and duties as are granted and imposed by this section and elsewhere by law.

(b) The advisory council shall consist of not less than nine members, nor more than 15 members, all but four of whom shall be appointed by the state Medicaid Agency and serve until replaced or reappointed on a rotating basis.

(c)(1) The heads of the Bureau of Public Health and Bureau for Medical Services are members ex officio.

(2) The cochairs of the Legislative Oversight Commission on Health and Human Resources Accountability, or their designees, are nonvoting ex officio members.

(3) The remaining members comprising the council consist of:

(A) One member of recognized ability in the field of medicine and surgery with respect to whose appointment the state Medical Association shall be afforded the opportunity of making nomination of three qualified persons;

(B) One member of recognized ability in the field of dentistry with respect to whose appointment the state Dental Association shall be afforded the opportunity of nominating three qualified persons;

(C) One member chosen from a list of three persons nominated by the West Virginia Primary Care Association;

(D) One member chosen from a list of three persons nominated by the Behavioral Health Providers Association of West Virginia; and

(E) The remaining members chosen from persons of recognized ability in the fields of hospital administration, nursing and allied professions and from consumers groups, including Medicaid recipients, members of the West Virginia Directors of Senior and Community Services, labor unions, cooperatives and consumer- sponsored prepaid group practices plans.

(d) The council shall meet on call of the state Medicaid Agency.

(e) Each member of the advisory council shall receive reimbursement for reasonable and

necessary travel expenses for each day actually served in attendance at meetings of the council in accordance with the state's travel regulations. Requisitions for the expenses shall be accompanied by an itemized statement, which shall be filed with the Auditor and preserved as a public record.

(f) The advisory council shall assist the state Medicaid Agency in the establishment of rules, standards and bylaws necessary to carry out the provisions of this section and shall serve as consultants to the state Medicaid Agency in carrying out the provisions of this section.

§9-4-4. State general relief fund.

The special fund known as the "General Relief Fund of ..... County," established by chapter one, acts of the Legislature, first extraordinary session, 1936, shall be abolished as of June 30, 1972.

The state general relief fund, established by chapter one, acts of the Legislature, first extraordinary session, 1936, shall be continued and the fiscal responsibility for said fund shall be the responsibility of the state on and after July 1, 1972 as provided by this section and rules and regulations promulgated by the commissioner.

§9-4A-1. Legislative findings.

The Legislature finds and declares the following:

(a) Federal Medicaid laws encourage special recognition of disproportionate share hospitals for Medicaid reimbursement purposes.

(b) These same federal laws permit and encourage the state to fund the Medicaid program through flexible means, including public and private contributions to serve as the state share for purposes of federal financial participation.

(c) Because of state budget constraints, moneys paid to disproportionate share hospitals under the Medicaid program have not been sufficient to allow the hospitals to recover adequate reimbursement for the costs associated with providing appropriate services to Medicaid clients of this state.

(d) The policy of this state is to encourage disproportionate share hospitals to continue providing health care services to the needy citizens of West Virginia; such encouragement and support are increasingly important when combined with federal financial participation.

(e) Cost shifting is a serious problem and it is the intent of the Legislature to reduce cost shifting.

§9-4A-2. Creation of Medicaid uncompensated care fund.

(a) There is created in the state Treasury a special revolving fund known as the Medicaid uncompensated care fund. All moneys deposited or accrued in this fund shall be used exclusively:

(1) To provide the state's share of the federal Medicaid program funds in order to improve inpatient payments to disproportionate share hospitals; and

(2) To cover administrative cost incurred by the Department of Human Services and associated with the Medicaid program and this fund: *Provided*, That no expenditures may be made to cover said administrative costs for any fiscal year after 1992, except as appropriated by the Legislature.

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

(1) All public funds transferred by any public agency to the Medicaid program for deposit in the fund as contemplated or permitted by applicable federal Medicaid laws;

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

(3) Interest which accrued on amounts in the fund from sources identified in subdivisions (1) and (2) of this subsection; and

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

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

(d) Moneys received into the fund shall not be counted or credited as part of the legislative general appropriation to the state Medicaid program.

(e) The fund shall be administered by the Department of Human Services. Moneys shall be disbursed from the fund on a quarterly basis. The secretary of the department shall implement the provisions of this article prior to the receipt of any transfer, contribution, donation or bequest from any public or private source.

(f) All moneys expended from the fund after receipt of federal financial participation shall be allocated to reimbursement of inpatient charges and fees of eligible disproportionate share hospitals. Except for the payment of administrative costs as provided for in this section, appropriation from this fund for any other purposes is void.

§9-4A-2a. Medical services trust fund.

(a) The Legislature finds and declares that certain dedicated revenues should be preserved in trust for the purpose of stabilizing the state's Medicaid program and providing services for future federally mandated population groups in conjunction with federal reform.

(b) There is created a special account within the Department of Human Services, which shall be an interest-bearing account and may be invested in the manner permitted by §12-6-9 of this code, designated the medical services trust fund. Funds paid into the account shall be derived from the following sources:

(1) Transfers, by intergovernmental transfer, from the hospital services revenue account provided for in §16-1-15a of this code;

(2) All interest or return on investment accruing to the fund;

(3) Any gifts, grants, bequests, transfers or donations which may be received from any governmental entity or unit or any person, firm, foundation or corporation; and

(4) Any appropriations by the Legislature which may be made for this purpose.

(c) Expenditures from the fund are limited to the following:

(1) Payment of backlogged billings from providers of Medicaid services when cash-flow problems within the medical services fund do not permit payment of providers within federally required time limits; and

(2) Funding for services to future federally mandated population groups in conjunction with federal health care reform: *Provided*, That other Medicaid funds have been exhausted for the federally mandated expansion: *Provided, however*, That new optional services for which a state Medicaid plan amendment is submitted after May 1, 1993, which are not cost effective for the state, are eliminated prior to expenditure of any moneys from this fund for Medicaid expansion.

(3) Payment of the required state match for Medicaid disproportionate share payments in order to receive federal financial participation in the disproportionate share hospital program.

(d) Expenditures from the fund solely for the purposes set forth in subsection (c) of this section shall be authorized in writing by the Governor, who shall determine in his or her discretion whether any expenditure shall be made, based on the best interests of the state as a whole and its citizens, and shall designate the purpose of the expenditure. Upon authorization signed by the Governor, funds may be transferred to the medical services fund: *Provided*, That all expenditures from the medical services trust fund shall be reported forthwith to the Joint Committee on Government and Finance.

(e) Notwithstanding the provision of §12-2-2 of this code, moneys within the medical services trust fund may not be redesignated for any purpose other than those set forth in subsection (c) of this section, except that, upon elimination of the Medicaid program in conjunction with federal health care reform, moneys within the fund may be redesignated for the purpose of providing health care coverage or services in coordination with federal reform.

§9-4A-2b. Expansion of coverage to children and terminally ill.

(a) It is the intent of the Legislature that steps be taken to expand coverage to children and the terminally ill and to pay for this coverage by fully utilizing federal funds. To achieve this intention, the Department of Human Services shall undertake the following:

(1) The department shall provide a streamlined application form, which shall be no longer than two pages, for all families applying for medical coverage for children under any of the programs set forth in this section; and

(2) The department shall provide the option of hospice care to terminally ill West Virginians who otherwise qualify for Medicaid.

(3) The department shall accelerate the Medicaid option for coverage of Medicaid to all West Virginia children whose family income is below one hundred percent of the federal poverty guideline.

(b) Notwithstanding the provisions of §9-4A-2a of this code, the accruing interest in the medical services trust fund may be utilized to pay for the programs specified in subsection (a) of this section: *Provided*, That to the extent the accrued interest is not sufficient to fully fund the specified programs, the disproportionate share hospital funds paid into the medical services trust fund after June 30, 1994, may be applied to cover the cost of the specified programs.

(c) Annually on January 1, the department shall report to the Governor and to the Legislature information regarding the number of children and elderly covered by the programs in subdivisions (2) and (3) of subsection (a), the cost of services by type of service provided, a cost-benefit analysis of the acceleration and expansion on other insurers and the reduction of uncompensated care in hospitals as a result of the programs.

§9-4A-3.

Repealed.

Acts, 2000 Reg. Sess., Ch. 45.

§9-4A-4. Legislative reports.

(a) The Secretary of the Department of Human Services shall make an annual report to the Legislature on the use of the Medicaid uncompensated care fund.

(b) The health care cost review authority shall make an annual report to the Legislature on the impact of improved Medicaid inpatient payments resulting from the fund on nongovernmental payor health care costs.

§9-4B-1. Definitions.

The following words, when used in this article, have meanings ascribed to them in this section, except in those instances where the context clearly indicates a different meaning:

(a) "Board" means the physician/medical practitioner provider Medicaid enhancement board created to develop, review and recommend the physician/medical practitioner provider fee schedule;

(b) "Physician provider" means an allopathic or osteopathic physician, rendering services within this state and receiving reimbursement, directly as an individual provider or indirectly as an employee or agent of a medical clinic, partnership or other business entity;

(c) "Nurse practitioner" means a registered nurse qualified by virtue of his or her education and credentials and approved by the West Virginia board of examiners for registered professional nurses to practice as an advanced practice nurse independently or in a collaborative relationship with a physician;

(d) "Nurse-midwife" means a qualified professional nurse registered with the West Virginia board of examiners for registered professional nurses who by virtue of additional training is specifically qualified to practice nurse-midwifery according to the statement of standards for the practice of nurse-midwifery as set forth by the American college of nurse-midwives;

(e) "Physician assistant" means an assistant to a physician who is a graduate of an approved program of instruction in primary health care or surgery, has attained a baccalaureate or master's degree, has passed the national certification examination and is qualified to perform direct patient care services under the supervision of a physician;

(f) "Registered nurse first assistant" means one who:

(1) Holds a current active registered nurse licensure;

(2) Is certified in perioperative nursing; and

(3) Has successfully completed and holds a degree or certificate from a recognized program which consists of:

(A) The association of operating room nurses, inc., care curriculum for the registered nurse first assistant; and

(B) One year of post-basic nursing study, which shall include at least forty-five hours of didactic instruction and one hundred twenty hours of clinical internship or its equivalent of two college semesters;

A registered nurse who was certified by the certification board of perioperative nursing before one thousand nine hundred ninety-seven is not required to fulfill the requirements of

subdivision (3) of this subsection;

(g) "Perioperative nursing" means a practice of nursing in which the nurse provides preoperative, intraoperative and post-operative nursing care to surgical patients;

(h) "Secretary" means the Secretary of the Department of Human Services; and

(i) "Single state agency" means the single state agency for Medicaid in this state.

§9-4B-2. Physician/medical practitioner provider Medicaid enhancement board; continuation and composition.

There is hereby continued the West Virginia physician/medical practitioner provider Medicaid enhancement board to consist of eleven members. The board shall consist of ten members, appointed by the Governor, and the secretary, or his or her designee, who shall serve as an ex officio, nonvoting member. The members appointed by the Governor shall include five allopathic physicians, one osteopathic physician, one nurse practitioner, one nurse-midwife, and one physician assistant and one lay person. The Governor shall select four allopathic physician board members from a list of eight recommendations submitted to the Governor by the state medical association, one allopathic physician board member from a list of three recommendations submitted to the Governor by the state academy of family physicians, the osteopathic physician board member from three recommendations submitted to the Governor by the state osteopathic society, the nurse practitioner from three recommendations submitted to the Governor by the advanced nursing practice conference group of the West Virginia nurses association, the nurse-midwife from three recommendations submitted to the Governor by the West Virginia chapter of the American college of nurse-midwives, the physician assistant from three recommendations submitted to the Governor by the state physician assistant association and the lay board member, at his or her discretion. The respective associations shall submit their recommendations to the Governor within five days of the effective date of this article. The Governor shall make all appointments within fifteen days from the receipt of all recommendations. After the initial appointment of the board, any appointment to fill a vacancy shall be for the unexpired term only, made in the same manner as the initial appointment, and the terms of all members expire on July 1, 1996. The board shall select a member to act as chairperson. The chairperson shall be the chief administrative officer and shall preside over official transactions of the board.

§9-4B-3. Expenses for citizen members.

Each appointed board member shall serve without compensation but shall be reimbursed for the cost of reasonable and necessary expenses actually incurred in the performance of his or her duties.

§9-4B-4. Powers and duties.

(a) The board shall:

(1) Develop and recommend a reasonable physician/medical practitioner provider fee schedule that conforms with federal Medicaid laws and remains within the limits of annual funding available to the single state agency for the Medicaid program. In developing the fee schedule, the board may refer to a nationally published regional specific fee schedule selected by the Secretary of the Department of Human Services. The board may consider identified health care priorities in developing its fee schedule to the extent permitted by applicable federal Medicaid laws and may recommend higher reimbursement rates for basic primary and preventive health care services than for other services. If the single state agency approves the fee schedule, it shall implement the physician/medical practitioner provider fee schedule;

(2) Review the fee schedule on a quarterly basis and recommend to the single state agency any adjustments it considers necessary. If the single state agency approves any of the board's recommendations, it shall immediately implement those adjustments and shall report the same to the Joint Committee on Government and Finance on a quarterly basis;

(3) Meet and confer with representatives from each medical specialty area so that equity in reimbursement increases or decreases be achieved to the greatest extent possible;

(4) Assist and enhance communications between participating physician and medical practitioner providers and the Department of Human Services; and

(5) Review reimbursements in relation to those physician and medical practitioner providers who provide early and periodic screening diagnosis and treatment.

(b) The board may carry out any other powers and duties as prescribed for it by the secretary.

(c) Nothing in this section gives the board the authority to interfere with the discretion and judgment given to the single state agency that administers the state's Medicaid program. If the single state agency disapproves the recommendations or adjustments to the fee schedule, it is expressly authorized to make any modifications to fee schedules as are necessary to ensure that total financial requirements of the agency for the current fiscal year with respect to the state's Medicaid plan are met and shall report the same to the Joint Committee on Government and Finance on a quarterly basis: *Provided*, That the single state agency shall provide reimbursement for the services of a registered nurse first assistant which reimbursement shall be no less than thirteen and six tenths of one percent of the rate for a surgeon physician. The purpose of the board is to assist and enhance the role of the single state agency in carrying out its mandate by acting as a means of communication between the Medicaid provider community and the agency.

(d) On a quarterly basis, the single state agency and the board shall report to the Joint Committee on Government and Finance the status of the fund, any adjustments to the fee schedule and the fee schedule for each health care provider group identified in section one of this article.

§9-4B-5.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4B-6.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4B-7. Effective date.

The physician provider fee schedule, as adopted by the single state agency through recommendations by the board, becomes effective on January 1, 1992.

§9-4B-8.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4C-1. Definitions.

The following words when used in this article have the meanings ascribed to them in this section, except in those instances where the context clearly indicates a different meaning:

(a) "Ambulance service provider" means a person rendering ambulance services within this state and receiving reimbursement, directly as an individual provider or indirectly as an employee or agent of a medical clinic, partnership or other business entity.

(b) "General health care provider" means an audiologist, a behavioral health center, a chiropractor, a community care center, an independent laboratory, an independent X ray service, an occupational therapist, an optician, an optometrist, a physical therapist, a podiatrist, a private duty nurse, a psychologist, a rehabilitative specialist, a respiratory therapist and a speech therapist rendering services within this state and receiving reimbursement, directly as an individual provider or indirectly as an employee or agent of a medical clinic, partnership or other business entity.

(c) "Inpatient hospital services provider" means a provider of inpatient hospital services for purposes of Section 1903(w) of the Social Security Act.

(d) "Intermediate care facility for individuals with an intellectual disability services provider" means a provider of intermediate care facility services for individuals with an intellectual disability for purposes of Section 1903(w) of the Social Security Act.

(e) "Nursing facility services provider" means a provider of nursing facility services for purposes of Section 1903(w) of the Social Security Act.

(f) "Outpatient hospital service provider" means a hospital providing preventative, diagnostic, therapeutic, rehabilitative or palliative services that are furnished to outpatients.

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

(h) "Single state agency" means the single state agency for Medicaid in this state.

§9-4C-2. General Medicaid enhancement board.

(a) The general Medicaid enhancement board created by this section is hereby continued in all respects, except as otherwise provided in this section. Current members of the board who represent groups not represented on the board on and after the effective date of this article shall not serve on the board after such date. The Governor shall appoint new members to the board to represent groups not previously represented on the board within thirty days after the effective date of this article.

(b) This board shall consist of members appointed by the Governor, including one representative from each of the following sixteen groups: Audiologists, behavioral health centers, chiropractors, community care centers, independent laboratory services, independent x-ray services, occupational therapists, opticians, optometrists, physical therapists, podiatrists, private duty nurses, psychologists, rehabilitative specialists, respiratory therapists and speech therapists. In addition to the members appointed by the Governor, the secretary, or his or her designee, shall serve as an ex officio, nonvoting member of the board.

(c) After the initial appointment of the board, any appointment to fill a vacancy shall be for the unexpired term only and shall be made in the same manner as the initial appointment. The terms of the lay persons who are members of the board as of March 17, 1994, shall expire on July 1, 1994.

(d) The terms of all members expire on July 1, 1996.

§9-4C-3. Dentist provider Medicaid enhancement board.

There is hereby continued the dentist provider Medicaid enhancement board to consist of five members. In order to carry out the purposes of this article, the dentist provider Medicaid enhancement board shall represent dentist providers. The board shall consist of three dentists, one lay person and the secretary, or his or her designee, who shall serve as an ex officio, nonvoting member. The Governor shall select the dentist members from six recommendations submitted to the Governor by the state dental association and the lay board member at his or her discretion. The state dental association shall submit all recommendations to the Governor within five days of the effective date of this article. The Governor shall make all appointments within fifteen days of receipt of all recommendations. After the initial appointment of the board, any appointment to fill a vacancy shall be for the unexpired term only, shall be made in the same manner as the initial appointment, and the terms of all members shall expire on July 1, 1996.

§9-4C-4. Ambulance service provider Medicaid enhancement board.

There is hereby continued the ambulance service provider Medicaid enhancement board to consist of seven members. In order to carry out the purpose of this article, this board shall represent ambulance service providers. The board shall consist of five ambulance service providers, one lay person and the secretary, or his or her designee, as an ex officio, nonvoting member. The Governor shall make all appointments within twenty days of the effective date of this article. After the initial appointment of the board, any appointment to fill a vacancy shall be for the unexpired term only, and the terms of all members shall expire on July 1, 1996.

§9-4C-5. Facility providers' Medicaid enhancement board.

(a) The outpatient hospital Medicaid enhancement board created by this section shall cease to exist on the effective date of this article.

(b) There is hereby continued the facility providers' Medicaid enhancement board to consist of seven members. In order to carry out the purpose of this article, the board shall represent ambulatory surgical centers, inpatient hospital service providers, outpatient hospital service providers, nursing facility service providers and intermediate care facility for individuals with an intellectual disability service providers.

(c) The board shall consist of one representative from each of the aforementioned classes of health care providers, one lay person and the secretary, or his or her designee, who shall serve as an ex officio, nonvoting member. The Governor shall make all appointments within thirty days after the effective date of this article.

(d) After initial appointment of the board, any appointment to fill a vacancy shall be for the unexpired term only, shall be made in the same manner as the initial appointment, and the terms of all members shall expire on July 1, 1996.

§9-4C-6. Expenses for citizen members.

Each appointed board member for each board created pursuant to this article shall serve without compensation but shall be reimbursed for the cost of reasonable and necessary expenses actually incurred in the performance of his or her duties.

§9-4C-7. Powers and duties.

(a) Each board created pursuant to this article shall:

(1) Develop, recommend, and review reimbursement methodology where applicable, and develop and recommend a reasonable provider fee schedule, in relation to its respective provider groups, so that the schedule conforms with federal Medicaid laws and remains within the limits of annual funding available to the single state agency for the Medicaid program. In developing the fee schedule the board may refer to a nationally published regional specific fee schedule, if available, as selected by the secretary in accordance with §9-4C-8 of this code. The board may consider identified health care priorities in developing its fee schedule to the extent permitted by applicable federal Medicaid laws, and may recommend higher reimbursement rates for basic primary and preventative health care services than for other services. In identifying basic primary and preventative health care services, the board may consider factors, including, but not limited to, services defined and prioritized by the basic services task force of the health care planning commission in its report issued in December of the year 1992; and minimum benefits and coverages for policies of insurance as set forth in and minimum benefits and coverages for policies of insurance as set forth in chapter thirty-three of this code and rules of the Insurance Commissioner promulgated thereunder. If the single state agency approves the adjustments to the fee schedule, it shall implement the provider fee schedule;

(2) Review its respective provider fee schedule on a quarterly basis and recommend to the single state agency any adjustments it considers necessary. If the single state agency approves any of the board's recommendations, it shall immediately implement those adjustments;

(3) Assist and enhance communications between participating providers and the Department of Human Services;

(4) Meet and confer with representatives from each specialty area within its respective provider group so that equity in reimbursement increases or decreases may be achieved to the greatest extent possible and when appropriate to meet and confer with other provider boards; and

(5) Appoint a chairperson to preside over all official transactions of the board.

(b) Each board may carry out any other powers and duties as prescribed to it by the secretary.

(c) Nothing in this section gives any board the authority to interfere with the discretion and judgment given to the single state agency that administers the state's Medicaid program. If the single state agency disapproves the recommendations or adjustments to the fee schedule, it is expressly authorized to make any modifications to fee schedules as are necessary to ensure that total financial requirements of the agency for the current fiscal

year with respect to the state's Medicaid plan are met and shall report such modifications to the Joint Committee on Government and Finance on a quarterly basis. The purpose of each board is to assist and enhance the role of the single state agency in carrying out its mandate by acting as a means of communication between the health care provider community and the agency.

(d) In addition to the duties specified in subsection (a) of this section, the ambulance service provider Medicaid board shall develop a method for regulating rates charged by ambulance services.

§9-4C-8. Duties of Secretary of Department of Human Services.

(a) The secretary, or his or her designee, shall serve on each board created pursuant to this article as an ex officio, nonvoting member and shall keep and maintain records for each board.

(b) In relation to outpatient hospital services, the secretary shall furnish information needed for reporting purposes. This information includes, but is not limited to, the following:

(1) For each hospital, the amount of payments and related billed charges for hospital outpatient services each month;

(2) The percentage of the state's share of Medicaid program financial obligation from time to time as necessary; and

(3) Any other financial and statistical information necessary to determine the net effect of any cost shift.

(c) The secretary shall determine an appropriate resolution for conflicts arising between the various boards.

(d) The secretary shall purchase nationally published fee schedules to be used, if available, as a reference by the Medicaid enhancement boards in developing fee schedules.

§9-4C-9.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4C-10.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4C-11. Effective date.

The provider fee schedules as adopted by the single state agency through recommendations by each board become effective on January 1, 1992: Provided, That those fee schedules based upon fees that require prior approval of the health care financing administration are effective on the effective date approved by the health care financing administration: Provided, however, That for those fees subject to an established Medicare upper limit, the effective date is the first day of the month immediately succeeding the date the fees can be raised sufficiently to comply with section ten of this article.

§9-4C-12.

Repealed.

Acts, 1993 1st Ex. Sess., Ch. 7.

§9-4D-1. Legislative findings.

(a) The Legislature finds that there are many individuals in this state who have disabilities that qualify them for state or federal assistance and who are nonetheless willing and able to enter the workforce, but do not do so out of fear of losing essential medical care. As a result, the state realizes increased costs in fully supporting these disabled individuals who, in turn, suffer under an additional disability of being deprived of the additional income, dignity and self-sufficiency derived by being engaged in competitive employment.

(b) The Legislature finds that establishing a Medicaid buy-in program for certain individuals with disabilities will assist them in becoming independent of public assistance by enabling them to enter the workforce without fear of losing essential medical care.

§9-4D-2. Definitions.

As used in this article:

(1) "Approved accounts" means any retirement account that the secretary has determined is not to be included as an asset in determining the eligibility of an individual for participation in the buy-in program. Approved accounts may include, but not be limited to, private retirement accounts such as individual retirement accounts; other individual accounts; and employer-sponsored retirement plans such as 401(k) plans, Keogh plans and employer pension plans.

(2) "Basic coverage group" means an optional coverage group as defined by the Ticket to Work and Work Incentives Improvement Act of 1999.

(3) "Copayment" is a fixed fee to be paid by the patient at the time of each office visit, outpatient service or filling of prescriptions.

(4) "Cost-sharing" means the eligible participant will participate in the cost of the program by paying the enrollment fee, monthly premiums and copayments if established by the department.

(5) "Countable income" means income that does not exceed two hundred fifty percent of the federal poverty level: *Provided*, That for purposes of this article, countable income does not include:

(A) The income of the individual's spouse, parent or guardian with whom he or she resides; and

(B) Income disregarded under the state Medicaid plan's financial methodology, including income disregarded under the federal supplemental security income program (42 U.S.C. §1382) as impairment-related work expenses.

(6) "Countable resources" includes earned and unearned income: *Provided*, That countable resources do not include:

(A) Liquid assets of up to $5,000 for an individual;

(B) Liquid assets of up to $10,000 for a family;

(C) Retirement accounts; and

(D) Independence accounts.

(7) "Department" means the Department of Human Services.

(8) "Disability" means a medically determinable physical or mental condition that:

(A) Can be expected to result in death or has lasted, or can be expected to last, for a continuous period of not less than twelve months; and

(B) Renders a person unable to engage in substantial gainful activity; and

(C) Is a disability defined by social security administration criteria and has been determined by either the social security administration or the department.

(9) "Eligible buy-in participant" means an individual who:

(A) Is a resident of the State of West Virginia;

(B) Has a disability as defined herein;

(C) Is at least sixteen years of age and less than sixty-five years of age;

(D) Is engaged in competitive employment, including self-employment or nontraditional work that results in remuneration at or above minimum wage in an integrated setting;

(E) Has countable resources that do not exceed the resource limits as defined in this article; and

(F) Has countable income that does not exceed the income limits as defined in this article.

(10) "Enrollment fee" means a one-time fee to participate in the Medicaid buy-in program.

(11) "Federal benefit rate" is the amount of monthly federal or state benefits paid to persons with limited income and resources who are age sixty-five or older, blind or disabled.

(12) "Federal poverty level" means the level of personal or family income below which one is classified as poor according to federal governmental standards, commonly referred to as the federal poverty guidelines which are issued and printed each year in the federal register.

(13) "Income" means money earned from employment wages or self-employment earnings and unearned money received from any other source.

(14) "Independence accounts" are department-approved accounts established with the department solely by funds paid from the earned income of an eligible buy-in participant to cover expenses necessary to enhance or maintain his or her independence or increase employment opportunities. Approved expenditures from the funds may include: Educational expenses; work-related expenses; home purchase or modification; transportation; medical expenses; assistive technology and related services; or for short-term living expenses in times of qualified emergencies as determined by the department.

(15) "Liquid assets" are cash or assets payable in cash on demand, including financial instruments that can be converted to cash within twenty working days. For purposes of this

article, national, state and local holidays are not working days.

(16) "Premium" is a monthly fee paid by an eligible buy-in participant to continue participation in the program.

(17) "Resources" are possessions that the eligible buy-in participant owns that could be changed to cash and used for food, clothing or shelter and that qualify as resources under the applicable social security administration guidelines.

(18) "Retirement accounts" are moneys invested in approved retirement funds and accounts that are disregarded as an asset by the department in determining the eligibility of an individual for participation in the buy-in program.

§9-4D-3. Medicaid buy-in program; funding.

(a) The Medicaid buy-in program for working individuals with disabilities is hereby established to provide Medicaid benefits to individuals who are disabled and employed, as authorized under Section 201 of the federal Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170, 42 U.S.C. 1396, et seq.). The Medicaid buy-in program shall become effective as of July 1, 2003.

(b) Funding for the buy-in program shall be from funds appropriated by the Legislature, premiums paid, enrollment fees and any federal matching funding available to the program.

§9-4D-4. Eligibility guidelines.

(a) To be eligible to participate in the buy-in program beginning July 1, 2003, an individual shall:

(1) Be a resident of the State of West Virginia;

(2) Have a disability that is defined and determined by the social security administration or the department;

(3) Be at least sixteen years of age but not more than sixty-four years of age;

(4) Be engaged in competitive employment, including self-employment or nontraditional work that results in remuneration at or above minimum wage in an integrated setting;

(5) Have countable resources that do not exceed the resource limit for the supplemental security income program;

(6) Have countable income that does not exceed two hundred fifty percent of the federal poverty level;

(7) Have total countable unearned income, using the social security income program methodology, that does not exceed the federal benefit rate plus the general income exclusion; and

(8) Except as provided in section five of this article, not have countable resources that exceed the resource limits for the federal supplemental security income program.

(b) The secretary shall establish a method of providing notice of the availability of participation in the Medicaid buy-in program. The secretary shall develop all forms and notices necessary to implement the provisions of this article, including forms for application to the program, determination of eligibility and continued participation and notices that advise all eligible buy-in participants of the rights, benefits, obligations and participation requirements of the program, including, but not limited to, notice of fees, premiums, premium adjustments, periodic review, length of time for which benefits may be paid and disqualifying factors.

§9-4D-5. Exceptions to qualifying factors.

(a) An individual who is enrolled in the buy-in program and who no longer meets the eligibility requirements of the basic coverage group due to an improvement in the individual's medical condition may continue to be eligible for Medicaid coverage under the buy-in program if the individual meets the following requirements:

(1) The individual continues to have a severe medically determinable impairment as determined by the department and as defined and recognized by federal law;

(2) The individual is employed and earning a monthly wage that is not less than the federal minimum hourly wage times forty;

(3) The individual does not have income or countable resources in excess of the limits established for the basic coverage group;

(4) The individual is at least sixteen years of age and less than sixty-five years of age;

(5) The individual pays any premiums or other cost sharing required under this chapter; and

(6) The individual meets all other eligibility requirements under this section.

(b) An individual who is enrolled in the buy-in program and who is unable to maintain employment for involuntary reasons, including temporary leave due to a health problem or involuntary termination, may continue to be eligible for Medicaid coverage under the buy-in program if the individual meets the following requirements:

(1) Within thirty days after the date on which the individual becomes unemployed, the individual, or an authorized representative of the individual, submits a written request to the office that the individual's Medicaid coverage be continued;

(2) The individual maintains a connection to the workforce during the individual's continued eligibility period by participating in at least one of the following activities:

(A) Enrollment in a state or federal vocational rehabilitation program;

(B) Enrollment or registration with the office of workforce development;

(C) Participation in a transition from school-to-work program;

(D) Participation with an approved provider of employment services;

(E) Provision of documentation from the individual's employer that the individual is on temporary involuntary leave;

(F) The individual does not have income or countable resources in excess of the limits established under this section;

(G) The individual is at least sixteen years of age and less than sixty-five years of age;

(H) The individual pays any premiums or other cost sharing required under this section; and

(I) The individual meets all other eligibility requirements under this section.

(c) The department shall continue Medicaid coverage under the buy-in program for an individual described in subsection (b) of this section for up to six months from the date of the individual's involuntary loss of employment.

(d) If an individual is ineligible for continued coverage under the buy-in program because he or she fails to meet the requirements of subsection (b) of this section or has already fulfilled twelve months of continuing eligibility, the individual shall be required to meet the eligibility requirements of another available Medicaid program in order to continue to be eligible for Medicaid benefits.

§9-4D-6. Fees, premiums and periodic reviews.

(a) The department shall charge a $50 enrollment fee to all participants in the Medicaid buy-in program. Upon payment of the enrollment fee, the first month's premium payment is waived. Medicaid coverage begins on the first day of the month following payment of the enrollment fee.

(b) The department shall develop a sliding scale of premiums for individuals participating in the buy-in program. The sliding scale shall:

(1) Be based on the annual gross income of the individual; and

(2) Provide for a minimum premium of $15 and a maximum monthly premium not to exceed three and one-half percent of the individual's gross monthly income.

(c) Subject to the minimum and maximum amounts described in this section, the department may annually adjust the scale of premiums charged for participation in the Medicaid buy-in program.

(d) The department shall biannually review the amount of the premium that an individual is required to pay under this section.

(e) The department may increase the premium required only after conducting a review.

(f) The department shall decrease the premium that an eligible buy-in participant is required to pay if:

(1) The individual notifies the office of a change in income or family size; and

(2) The sliding scale adopted by the department applied to the individual's changed circumstances prescribes a premium for the individual that is lower than the premium the individual is paying.

(g) The department shall establish administrative procedures regarding premiums for the buy-in program, including:

(1) The effect of nonpayment of a premium; and

(2) The collection of premiums.

(h) The department shall establish criteria to base the biannual redetermination of disability required for an individual participating in the buy-in program on the individual's medical evidence, including evidence of physical or mental impairment.

(i) In conducting the biannual redetermination described in this section, the department may not determine that an individual participating in the buy-in program is no longer disabled

solely on the individual's:

(1) Participation in employment;

(2) Earned income; or

(3) Income from self-employment.

§9-4D-7. Benefits of the Medicaid buy-in program.

(a) Except as otherwise provided in this article, an eligible buy-in participant shall receive the same benefits that he or she would otherwise receive as a recipient of Medicaid benefits, including home health care services.

(b) Except as otherwise provided in this article, an eligible buy-in participant is subject to the same obligations and requirements, including cost sharing, that he or she would otherwise be subject to as recipient of Medicaid benefits.

§9-4D-8. Analytical criteria and reporting requirements.

(a) The secretary shall establish criteria to determine the effectiveness of the Medicaid buy-in program and continued Medicaid coverage through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h). The criteria shall include an analysis of the following:

(1) The number of individuals with disabilities who are:

(A) Enrolled in the buy-in program; or

(B) Receiving Medicaid through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h);

(2) The amount of state revenues resulting from premiums paid by participants in the buy-in program; and

(3) The amount of state costs incurred as a result of implementing the buy-in program, including administrative costs and costs of providing services.

(b) In addition to the criteria required under subsection (b) of this section, the secretary may establish criteria to determine the following:

(1) Comparative costs of Medicaid funded services for participants in the buy-in program and work incentives created through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h) before and after employment;

(2) The number of supplemental security income and social security disability insurance recipients in West Virginia who are no longer dependent on, or who have reduced dependence on, public assistance or health care entitlement services, other than Medicaid or the Children's Health Insurance Program, due to participation in the buy-in program or work incentives created through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h);

(3) The number of individuals with severe disabilities who are no longer dependent on, or who have reduced dependence on, public benefits or services, other than Medicaid or the Children's Health Insurance Program, due to income or support services received through participation in the buy-in program or work incentives created through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h); and

(4) The change in the number of buy-in program participants or participants in work incentives created through Section 1619 of the federal Social Security Act (42 U.S.C. §1382h) who have health care needs and related services covered through employer based benefit programs.

(c) In evaluating the effectiveness of the state's work incentives initiatives for individuals with disabilities, the secretary:

(1) Shall collaborate with other state agencies on data collection; and

(2) May consult with an independent contractor to collect data on the criteria required by this section.

(d) The department secretary shall provide an annual report of its evaluation of the Medicaid buy-in program performed pursuant to the requirements of this section to the Legislature no later than the last day of December of each year, beginning in two thousand four.

§9-4D-9. Advisory council; rules.

(a) The secretary of the department shall establish a Medicaid buy-in program advisory council, consisting of representatives from the state Medicaid agency, the state rehabilitation agency, the state office of family support, the West Virginia statewide independent living council, the West Virginia state rehabilitation council, the West Virginia developmental disabilities council, the West Virginia mental health planning council and the center for excellence in disabilities at West Virginia University.

(b) The secretary shall submit proposed rules for review and input to the advisory council prior to release for public comment and shall consider any recommendations of the advisory council before adopting final rules.

(c) The secretary shall propose emergency rules in accordance with the provisions of 29A-3-15 of this code to implement the provisions of this article. Thereafter, the secretary shall propose additional rules for legislative approval in accordance with the provisions of said article three, chapter twenty-nine-a of this code as may be needed to administer and maintain the Medicaid buy-in program.

§9-4E-1. Purpose.

(a) The purpose of this program shall be to reduce Medicaid costs for long-term care by encouraging the purchase of private long-term care insurance policies that are covered under the "qualified state long-term care insurance partnerships."

(b) It is the intent of the long-term care partnership to do all of the following:

(1) Provide incentives for individuals to insure against the costs of providing for their long-term care needs.

(2) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(3) Alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

§9-4E-2. Definitions.

(a) "Asset disregard" means, with regard to the state's medical assistance program, disregarding any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care insurance partnership policy.

(b) "Long-term care insurance" means a policy described in section four (a), article fifteen (A), chapter thirty-three of this code.

(c) "Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in 42 U.S.C. 1396, Section 1917(b) of the Social Security Act.

(d) "Medicaid" means that assistance provided under a state plan implemented by subchapter nineteen, chapter seven, Title 42, United States Code, as that chapter has been and may hereafter be amended.

§9-4E-3. Authority.

(a) The program shall be administered by the Bureau for Medical Services. The bureau shall establish a long-term care partnership program in West Virginia in order to provide for the financing of long-term care through a combination of private insurance and Medicaid in accordance with federal requirements on qualified state long-term care insurance partnerships.

(b) Not later than ninety days after the effective date of this article, the Bureau for Medical Services shall file a state plan amendment, pursuant to Title XIX of the United States Social Security Act and any amendments thereto, to the United States Department of Health and Human Services to establish that the assets an individual owns and may retain under Medicaid and still qualify for benefits under Medicaid at the time the individuals applies for benefits is increased dollar-for-dollar for each dollar paid out under the individuals's long-term care insurance policy if the individual is a beneficiary of a qualified long-term care partnership program policy.

(c) An individual who is a beneficiary of a West Virginia long-term care partnership program and meets eligibility requirements is eligible for assistance under the state's medical assistance program using the asset disregard as provided under subsection (b).

(d) The Bureau of Medical Services shall pursue reciprocal agreements with other states to extend the asset disregard to West Virginia residents who purchased long-term care partnership policies in other states that are compliant with Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005, PL 109-171, and any applicable federal regulations or guidelines.

(e) Upon diminishment of assets below the anticipated remaining benefits under a long-term care partnership program policy, certain assets of an individual, as provided under subsection (b), shall not be considered when determining any of the following:

(1) Medicaid eligibility;

(2) The amount of any Medicaid payment;

(3) Any subsequent recovery by the state of a payment for medical services or long-term care services.

(f) If the long-term care partnership program is discontinued, an individual who purchased a West Virginia long-term care partnership program policy before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by Title VI, Section 6021 of the Federal Deficit Reduction Act of 2005, PL 109-171.

§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.

§9-6-1. Definitions.

As used in this article:

(1) "Adult protective services agency" means any public or nonprofit private agency, corporation, board, or organization furnishing protective services to adults;

(2) "Adult protective services" means services provided to vulnerable adults as the secretary may specify and may include, but are not limited to, services such as:

(A) Receiving reports of adult abuse, neglect, or exploitation;

(B) Investigating the reports of abuse, neglect, or exploitation;

(C) Case planning, monitoring, evaluation, and other case work and services; and

(D) Providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services;

(3) "Abuse" means the infliction or threat of physical or psychological harm, including the use of undue influence or the imprisonment of any vulnerable adult or facility resident;

(4) "Neglect" means the unreasonable failure by a caregiver to provide the care necessary to maintain the safety or health of a vulnerable adult or self-neglect by a vulnerable adult, including the use of undue influence by a caregiver to cause self-neglect;

(5) "Vulnerable adult" means any person over the age of 18, or an emancipated minor, who by reason of physical or mental condition is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health and protection;

(6) "Emergency" or "emergency situation" means a situation or set of circumstances which presents a substantial and immediate risk of death or serious injury to a vulnerable adult;

(7) "Financial exploitation" means the intentional misappropriation, misuse, or use of undue influence to cause the misuse of funds or assets of a vulnerable adult or facility resident, but does not apply to a transaction or disposition of funds or assets where a person made a good-faith effort to assist the vulnerable adult or facility resident with the management of his or her money or other things of value;

(8) "Legal representative" means a person lawfully invested with the power, and charged with the duty, of taking care of another person or with managing the property and rights of another person, including, but not limited to, a guardian, conservator, durable power of attorney representative, springing power of attorney representative, financial power of attorney representative, medical power of attorney representative, trustee, or other duly appointed person;

(9) "Nursing home" or "facility" means any institution, residence, intermediate care facility for individuals with an intellectual disability, care home, or any other adult residential facility, or any part or unit thereof, that is subject to the provisions of §16-5C-1 *et seq.*, §16-5D-1 *et seq.*, §16-5E-1 *et seq.*, or §16-5H-1 *et seq*. of this code;

(10) "Regional long-term care ombudsman" means any paid staff of a designated regional long-term care ombudsman program who has obtained appropriate certification from the Bureau of Senior Services and meets the qualifications set forth in §16-5L-7 of this code;

(11) "Facility resident" means an individual living in a nursing home or other facility, as that term is defined in subdivision (9) of this section;

(12) "State long-term care ombudsman" means an individual who meets the qualifications of §16-5L-5 of this code and who is employed by the State Bureau of Senior Services to implement the State Long-term Care Ombudsman Program;

(13) "Secretary" means the Secretary of the Department of Human Services;

(14) "Caregiver" means an individual who is responsible for the care of a vulnerable adult or a facility resident, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an adult with disabilities or a facility resident who needs supportive services in any setting; and

(15) "Fiduciary" means a person or entity with the legal responsibility to make decisions on behalf of and for the benefit of another person; to act in good faith and with fairness; and includes a trustee, a guardian, a conservator, an executor or an agent under a financial power of attorney.

§9-6-2. Adult protective services; immunity from civil liability; rules; organization and duties.

(a) There is continued within the Department of Human Services the system of adult protective services.

(b) The secretary shall propose rules for legislative approval in accordance with the provisions of §29A-3-1 *et seq*. of this code regarding the organization and duties of the adult protective services system and the procedures to be used by the department to effectuate the purposes of this article. The rules may be amended and supplemented from time to time.

(c) The secretary shall design and arrange such rules to attain, or move toward the attainment of, the following goals to the extent that the secretary believes feasible under the provisions of this article within the state appropriations and other funds available:

(1) Assisting vulnerable adults who are abused, neglected, or financially exploited in achieving or maintaining self-sufficiency and self-support and preventing, reducing, and eliminating their dependency on the state;

(2) Preventing, reducing, and eliminating neglect, financial exploitation, and abuse of adults who are unable to protect their own interests;

(3) Preventing and reducing institutional care of adults by providing less intensive forms of care, preferably in the home;

(4) Referring and admitting abused, neglected, or financially exploited vulnerable adults to institutional care only where other available services are inappropriate;

(5) Providing services and monitoring to adults in institutions designed to assist adults in returning to community settings;

(6) Preventing, reducing, and eliminating the exploitation of vulnerable adults and facility residents through the joint efforts of the various agencies, the adult protective services system, the state and regional long-term care ombudsmen, administrators of nursing homes or other residential facilities, and county prosecutors;

(7) Preventing, reducing, and eliminating abuse, neglect, and financial exploitation of residents in nursing homes or facilities; and

(8) Coordinating investigation activities for complaints of financial exploitation, abuse, and neglect of vulnerable adults and facility residents among various agencies, the adult protective services system, the state and regional long-term care ombudsmen, administrators of nursing homes or other residential facilities, county prosecutors, if necessary, and other state or federal agencies or officials, as appropriate.

(d) An adult protective services caseworker may not be held personally liable for any

professional decision or action arrived at in the performance of his or her official duties as set forth in this section or agency rules promulgated: *Provided*, That nothing in this subsection protects any adult protective services worker from any liability arising from the operation of a motor vehicle or for any loss caused by willful and wanton misconduct or intentional misconduct.

(e) The rules proposed by the secretary shall provide for the means by which the department shall cooperate with federal, state, and other agencies to fulfill the objectives of the system of adult protective services.

§9-6-3. Cooperation among agencies; termination and reduction of assistance by commissioner.

The secretary shall direct the coordination of the investigation of complaints of abuse, neglect, or financial exploitation made pursuant to this article, and the various agencies of the department, the adult protective services system, the state and regional long-term care ombudsmen, administrators of nursing homes or other residential facilities, county prosecutors, and any other applicable state or federal agency shall cooperate among each other for the purposes of observing, reporting, investigating, and acting upon complaints of abuse, neglect, or financial exploitation of any vulnerable adult or facility resident in this state.

§9-6-4. Action to abate abuse, neglect, emergency, or financial exploitation.

The department or any reputable person may bring and maintain an action against any person having actual care, custody, or control of a vulnerable adult, for injunctive relief, including a preliminary injunction, to restrain and abate any abuse, neglect, or financial exploitation of a vulnerable adult or to abate an emergency situation. In any such proceeding the court shall appoint a guardian ad litem, to protect the interests of the vulnerable adult, who shall not be an employee of the state, nor be a party to the proceeding, nor be selected by, or in the employ of, any party to the proceeding: *Provided*, That the court may by order terminate assistance granted or paid to any person found to have abused, neglected, or financially exploited a vulnerable adult and order any such assistance to be paid to another person solely for the use and benefit of such abused, neglected, or financially exploited person, and grant such other equitable relief as may be appropriate in the circumstances to restrain and abate such abuse or neglect: *Provided, however*, That in the case of an action to abate an emergency situation, the court may grant the relief authorized in §9-6-5 of this code.

§9-6-5. Emergency immediate remedial treatment; procedure.

Whenever a circuit court shall find in an action to abate an emergency situation that there is probable cause to believe that a vulnerable adult is in an emergency situation and that the person or persons having the immediate care, custody, and control of such vulnerable adult refuses to take necessary steps to alleviate such emergency, or that such vulnerable adult is without the actual care, custody, and control of any persons, it may issue an order of attachment for such vulnerable adult and direct that the peace officer executing the same deliver such vulnerable adult in his custody to a hospital or other safe place except a jail, for immediate remedial treatment to reduce or avoid the risk of death or serious injury. In the event that an order of attachment is issued pursuant to this section, any peace officer executing the order, and such employees of the department the peace officer directs to accompany him, may enter into the place of abode to remove such vulnerable person, notwithstanding the residence therein of other persons.

If any employee or officer of the department shall by direct observation of a vulnerable adult not in the immediate care, custody, or control of another, have reasonable cause to believe that such vulnerable person is then and there in an emergency situation, then such officer or employee may offer transportation to a hospital or other safe place, other than a jail, to such vulnerable adult for immediate remedial treatment to reduce or avoid the risk of death or serious injury.

Immediately upon delivery of any vulnerable person to such hospital or other safe place, such officer or employee shall apply to the circuit court for and the court shall appoint, and in the case of an attachment the court shall contemporaneously with its issuance appoint, a guardian ad litem who shall not be an employee of the state, nor be an interested party, nor be selected by, nor in the employ of, any interested party, to represent the interests of such vulnerable adult, and the court shall fix a time, not later than one judicial day later, to determine if such remedial treatment shall continue or such vulnerable adult should be released. A copy of that attachment and notice of such hearing shall be served on any person in whose actual care, custody, and control such vulnerable adult is found. If further remedial treatment is required, application shall be promptly made to the county commission or such other proper tribunal for appropriate relief: *Provided,* That the commitment for further remedial treatment may be continued until proceedings for such appropriate relief be concluded: *Provided, however,* That application for release from such remedial treatment may be made and granted at any time that the emergency ceases.

§9-6-6. Payment and termination of payment for services to a vulnerable adult.

If any vulnerable adult requires and is granted remedial treatment for an emergency, or the department determines that a vulnerable adult is abused, neglected, or financially exploited, the department may pay any assistance granted for the use and benefit of such vulnerable adult to the person actually providing care for such adult, and terminate payments to any person alleged or shown to have abused, neglected, or financially exploited such vulnerable adult, or to whom such payments were made prior to such remedial treatment, for so long as such remedial treatment continues, or until such abuse, neglect, or financial exploitation is abated, and such vulnerable adult continues to be in the immediate care, custody, and control of such person.

§9-6-7. Comprehensive system of adult protective services; compulsory assistance prohibited.

The department shall develop a plan for a comprehensive system of adult protective services, including social casework, medical and psychiatric services, home care, day care, counseling, research, and others to achieve the goals of this article.

It shall offer such services as are available and appropriate in the circumstances to persons who, other than for compensation, have or intend to have the actual, physical custody and control of a vulnerable adult and to such vulnerable adults or to adults who may request and be entitled to such protective services: *Provided*, That except as expressly provided in this article, the department may not directly or indirectly compel the acceptance of such services by any person or discriminate against a person who refuses such services.

§9-6-8. Confidentiality of records.

(a) Except as otherwise provided in this section, all records of the department, state and regional long-term care ombudsmen, nursing home or facility administrators, the Office of Health Facility Licensure and Certification, and all protective services agencies concerning an adult or facility resident under this article are confidential and may not be released, except in accordance with the provisions of §9-6-11 of this code.

(b) Unless the vulnerable adult concerned is receiving adult protective services, or unless there are pending proceedings regarding the vulnerable adult, the records maintained by the adult protective services agency shall be destroyed 30 years following their preparation.

(c) Notwithstanding the provisions of subsection (a) of this section or any other provision of this code to the contrary, records concerning reports of abuse, neglect, or financial exploitation of a vulnerable adult, including all records generated as a result of such reports, may be made available to:

(1) Employees or agents of the department who need access to the records for official business;

(2) Any law-enforcement agency investigating a report of known or suspected abuse, neglect, or financial exploitation of a vulnerable adult;

(3) The prosecuting attorney of the judicial circuit in which the vulnerable adult resides or in which the alleged abuse, neglect, or financial exploitation occurred;

(4) A circuit court or the Supreme Court of Appeals subpoenaing the records. The court shall, before permitting use of the records in connection with any court proceeding, review the records for relevancy and materiality to the issues in the proceeding. The court may issue an order to limit the examination and use of the records or any part of the record;

(5) A grand jury, by subpoena, upon its determination that access to the records is necessary in the conduct of its official business;

(6) The recognized protection and advocacy agency for the disabled of the State of West Virginia;

(7) The victim; and

(8) The victim’s legal representative, unless he or she is the subject of an investigation under this article.

(d) Notwithstanding the provisions of subsection (a) of this section or any other provision of this code to the contrary, summaries concerning substantiated investigative reports of abuse, neglect, or financial exploitation of vulnerable adults may be made available to:

Any person who the department has determined to have abused, neglected, or financially exploited the victim.

(e) Notwithstanding the provisions of subsection (a) of this section or any other provision of this code to the contrary, summaries concerning substantiated and unsubstantiated investigative reports of abuse, neglect, or financial exploitation of vulnerable adults may be made available to:

(1) Any appropriate official of the state or regional long-term care ombudsman investigating a report of known or suspected abuse, neglect or financial exploitation of a vulnerable adult;

(2) Any person engaged in bona fide research or auditing, as defined by the department. However, information identifying the subjects of the report may not be made available to the researcher;

(3) Employees or agents of an agency of another state that has jurisdiction to investigate known or suspected abuse, neglect, or exploitation of vulnerable adults;

(4) A professional person when the information is necessary for the diagnosis and treatment of, and service delivery to, a vulnerable adult; and

(5) A department administrative hearing officer when the hearing officer determines the information is necessary for the determination of an issue before the officer.

(f) Notwithstanding the provisions of subsection (a), subsection (e), or any other provision of this code to the contrary, all records concerning substantiated and unsubstantiated referrals of financial exploitation of a vulnerable adult may be made available to the State Auditor's Office in order to carry out any investigations which that office or its appropriate divisions are required or authorized to undertake.

(g) The identity of any person reporting abuse, neglect, or financial exploitation of a vulnerable adult may not be released without that person's written consent to any person other than employees of the department responsible for protective services or the appropriate prosecuting attorney or law-enforcement agency. This subsection grants protection only for the person who reported the abuse, neglect, or financial exploitation and protects only the fact that the person is the reporter. This subsection does not prohibit the subpoena of a person reporting the abuse, neglect, or financial exploitation when deemed necessary by the prosecuting attorney or the department to protect a vulnerable adult who is the subject of a report, if the fact that the person made the report is not disclosed.

§9-6-9. Mandatory reporting of incidences of abuse, neglect, financial exploitation, or emergency situation.

(a) If any medical, dental, or mental health professional, Christian Science practitioner, religious healer, social service worker, law-enforcement officer, humane officer, any employee of any nursing home or other residential facility, has reasonable cause to believe that a vulnerable adult or facility resident is or has been neglected, abused, financially exploited or placed in an emergency situation, or if such person observes a vulnerable adult or facility resident being subjected to conditions that are likely to result in abuse, neglect, financial exploitation, or an emergency situation, the person shall immediately report the circumstances pursuant to the provisions of §9-6-11 of this code: *Provided*, That nothing in this article is intended to prevent individuals from reporting on their own behalf.

(b) In addition to those persons and officials specifically required to report situations involving suspected abuse, neglect, or financial exploitation of a vulnerable adult or facility resident, or the existence of an emergency situation, any other person may make such a report.

(c) The Department of Human Services shall develop and implement a procedure to notify any person mandated to report suspected abuse and neglect of a vulnerable adult or facility resident of whether an investigation into the reported suspected abuse, neglect, or financial exploitation has been initiated and when the investigation is completed.

(d) Financial institutions and their employees, as defined by §31A-2A-1 of this code and as permitted by §31A-2A-4(13) of this code, others engaged in financially related activities, as defined by §31A-8C-1 of this code, caregivers, relatives, and other concerned persons are permitted to report suspected cases of financial exploitation to state or federal law-enforcement authorities, the county prosecuting attorney, and to the Adult Protective Services Division, or Medicaid Fraud Division, as appropriate. Public officers and employees are required to report suspected cases of financial exploitation to the appropriate entities as stated above. The requisite agencies shall investigate or cause the investigation of the allegations.

§9-6-9a. Mandatory reporting suspected of animal cruelty by adult protective service workers.

In the event an adult protective service worker, in response to a report mandated by section nine of this article, forms a reasonable suspicion that an animal is the victim of cruel or inhumane treatment, he or she shall report the suspicion and the basis therefor to the county humane officer provided under section one, article ten, chapter seven of this code within twenty-four hours of the response to the report.

§9-6-10. Mandatory reporting to medical examiner or coroner; postmortem investigation.

(a) Any person or official who is required under §9-6-9 of this code to report cases of suspected abuse, neglect, or financial exploitation, and who has probable cause to believe that a vulnerable adult or facility resident has died as a result of abuse or neglect, shall report that fact to the appropriate medical examiner or coroner.

(b) Upon the receipt of such a report, the medical examiner or coroner shall cause an investigation to be made and shall report the findings to the local law-enforcement agency, the local prosecuting attorney, the department's local adult protective services agency, and, if the institution making a report is a hospital, nursing home, or other residential facility, to the administrator of the facility, the state and regional long-term care ombudsman, and the Office of Health Facility Licensure and Certification.

§9-6-11. Reporting procedures.

(a) A report of neglect, abuse, or financial exploitation of a vulnerable adult or facility resident, or of an emergency situation involving such an adult, shall be made immediately, and not more than 48 hours after suspecting abuse, neglect or financial exploitation, to the department's adult protective services agency by a method established by the department. The department shall, upon receiving any such report, take such action as may be appropriate and shall maintain a record thereof. The department shall receive reports on its 24-hour, seven-day-a-week, toll-free number established to receive calls reporting cases of suspected or known adult abuse or neglect.

(b) A copy of any report of abuse, neglect, financial exploitation, or emergency situation shall be immediately filed with the following agencies:

(1) The Department of Human Services;

(2) The appropriate law-enforcement agency and the prosecuting attorney, if necessary; or

(3) In case of a death, to the appropriate medical examiner or coroner's office.

(c) If the person who is alleged to be abused, neglected, or financially exploited is a resident of a nursing home or other residential facility, a copy of the report shall also be filed with the state or regional long-term care ombudsman and the administrator of the nursing home or facility.

(d) Reports of known or suspected institutional abuse, neglect, or financial exploitation of a vulnerable adult or facility resident, or the existence of an emergency situation in an institution, nursing home, or other residential facility shall be made, received, and investigated in the same manner as other reports provided for in this article. In the case of a report regarding an institution, nursing home, or residential facility, the department shall immediately cause an investigation to be conducted.

§9-6-12. Reporting person's immunity from liability.

(a) Any person who in good faith makes or causes to be made any report permitted or required by this article shall be immune from any civil or criminal liability which might otherwise arise solely out of making such report.

(b) No nursing home may discharge or in any manner discriminate against any resident, family member, legal representative or employee for the reason that he or she filed a complaint or participated in any matter or proceeding stemming from the provisions of this article.

(c) Violation of the prohibition contained in subsection (b) of this section by a nursing home or other residential facility constitutes grounds for the suspension or revocation of the license of the facility, if it operates under license pursuant to this code, or other appropriate measure.

§9-6-13. Abrogation of privileged communications.

The privileged status of communications between husband and wife, and with any person required to make reports under §9-6-9 or §9-6-10 of this code, except communications between an attorney and his or her client, is hereby abrogated in circumstances involving suspected or known abuse, neglect, or financial exploitation of a vulnerable adult, or where the vulnerable adult is in a known or suspected emergency situation.

§9-6-14. Failure to report; penalty.

Any person subject to the mandatory reporting provisions of this article who knowingly fails to make any report required herein or any person who knowingly prevents another person from making such a report is guilty of a misdemeanor, and, upon conviction thereof, shall be fined not more than $100 or imprisoned in the county jail for not more than ten days, or both fined and imprisoned.

§9-6-15.

Repealed.

Acts, 1997 Reg. Sess., Ch. 72.

§9-6-16. Compelling production of information.

(a)(1) In order to obtain information regarding the location of an adult who is the subject of an allegation of abuse, neglect, or financial exploitation, the Secretary may serve, by certified mail, personal service, or facsimile, an administrative subpoena on any corporation, partnership, business, or organization for production of information leading to determining the location of the adult. In case of disobedience to the subpoena, the Division of Adult Protective Services may petition any circuit court to require the production of information.

(2) In case of disobedience to the subpoena, in compelling the production of information, the secretary may invoke the aid of: (A) The circuit court with jurisdiction over the served party, if the entity served is located in this state; or (B) the circuit court of the county in which the local protective services office conducting the investigation is located, if the entity served is a nonresident.

(3) A circuit court shall not enforce an administrative subpoena unless it finds that: (A) The investigation is one the Division of Adult Protective Services is authorized to make and is being conducted pursuant to a legitimate purpose; (B) the inquiry is relevant to that purpose; (C) the inquiry is not too broad or indefinite; (D) the information sought is not already in the possession of the Division of Adult Protective Services; and (E) any administrative steps required by law have been followed.

(4) If circumstances arise where the secretary, or his or her designee, determines it necessary to compel an individual to provide information regarding the location of an adult who is the subject of an allegation of abuse, neglect, or financial exploitation, the secretary, or his or her designee, may seek a subpoena from the circuit court with jurisdiction over the individual from whom the information is sought.

§9-7-1. Legislative purpose and findings; powers and duties of fraud control unit; transfer to the Office of the Attorney General; legislative report.

(a) The Medicaid Fraud Control Unit shall have the following powers and duties:

(1) The investigation and referral for prosecution of all violations of applicable state and federal laws pertaining to the provision of goods or services under the medical programs of the state including the Medicaid program.

(2) The investigation of abuse, neglect, or financial exploitation of residents in board and care facilities and patients in health care facilities which receive payments under the medical programs of the state.

(3) To cooperate with the federal government in all programs designed to detect and deter fraud and abuse in the medical programs of the state.

(4) To employ and train personnel to achieve the purposes of this article and to employ legal counsel, investigators, auditors, and clerical support personnel and such other personnel as are deemed necessary from time to time to accomplish the purposes herein.

(b) The Medicaid Fraud Control Unit shall be within the Office of the Attorney General. All rights, responsibilities, powers, and duties of the unit shall be transferred to the Office of the Attorney General, including the administration and authority of the Medicaid Fraud Control Fund.

§9-7-2. Definitions.

For the purposes of this article:

"Assistance" means money payments, medical care, transportation and other goods and services necessary for the health or welfare of individuals, including guidance, counseling, and other welfare services and shall include all items of any nature contained within the definition of "welfare assistance" in §9-1-2 of this code.

"Benefits" means money payments, goods, services, or any other thing of value.

"Board and Care Facility" means a residential setting where two or more unrelated adults receive nursing services or personal care services.

"Claim" means an application for payment for goods or services provided under the medical programs of the Department of Human Services.

"Entity" means any corporation, association, partnership, limited liability company, or other legal entity.

"Financial Exploitation" means the intentional misappropriation or misuse of funds or assets of another.

"Fraud" means a knowing misrepresentation, knowing concealment, or reckless statement of a material fact.

"Medicaid" means that assistance provided under a state plan implemented pursuant to the provisions of subchapter nineteen, chapter seven, Title 42, United States Code, as that chapter has been and may hereafter be amended.

"Person" means any individual, corporation, association, partnership, proprietor, agent, assignee, or entity.

"Provider" means any individual or entity furnishing goods or services under the medical programs of the Department of Human Services.

"Unit" means the Medicaid Fraud Control Unit established under §9-7-1 of this code.

§9-7-3. Investigations; procedure.

(a) When the unit has credible information that indicates a person has engaged in an act or activity which is subject to prosecution under this article, the unit may make an investigation to determine if the act has been committed and, to the extent necessary for such purpose, the Attorney General, or an employee of the unit designated by the Attorney General, may administer oaths or affirmations and issue subpoenas for witnesses and documents relevant to the investigation, including information concerning the existence, description, nature, custody, condition, and location of any book, record, documents, or other tangible thing and the identity and location of persons having knowledge of relevant facts or any matter reasonably calculated to lead to the discovery of admissible evidence.

When the unit has probable cause to believe that a person has engaged in an act or activity which is subject to prosecution under this article, or §61-2-29 of this code, either before, during, or after an investigation pursuant to this section, the Attorney General, or an employee of the unit designated by the Attorney General, may request search warrants and present and swear or affirm criminal complaints.

(b) If documents necessary to an investigation of the unit shall appear to be located outside the state, the documents shall be made available by the person or entity within the jurisdiction of the state having control over the documents either at a convenient location within the state or, upon payment of reasonable and necessary expenses to the unit for transportation and inspection, at the place outside the state where the documents are maintained.

(c) Upon failure of a person to comply with a subpoena or subpoena duces tecum or failure of a person to give testimony without lawful excuse and upon reasonable notice to all persons affected thereby, the unit may apply to the circuit court of the county in which compliance is sought for appropriate orders to compel obedience with the provisions of this section.

(d) The unit shall not make public the name or identity of a person whose acts or conduct is investigated pursuant to this section or the facts disclosed in such investigation except as the same may be used in any legal action or enforcement proceeding brought pursuant to this article or any other provision of this code.

(e) The Secretary Department of Human Services shall fully cooperate with the Office of the Attorney General on any investigation, prosecution, or civil action conducted pursuant to this article. The secretary shall promptly provide the Attorney General with any information or document requested for the purposes of carrying out this article, to the extent permitted under federal law.

§9-7-3a. Agency lawyers assisting prosecutors.

Attorneys employed and assigned to the Medicaid Fraud Control Unit created by the provisions of section one of this article may assist in the prosecution of criminal violations of this article.

§9-7-4. Applications for medical assistance; false statements or representations; criminal penalties.

(a) A person shall not knowingly make or cause to be made a false statement or false representation of any material fact in an application for medical assistance under the medical programs of the department.

(b) A person shall not knowingly make or cause to be made a false statement or false representation of any material fact necessary to determine the rights of any other person to medical assistance under the medical programs of the department.

(c) A person shall not knowingly and intentionally conceal or fail to disclose any fact with the intent to obtain medical assistance under the medical programs of the department to which the person or any other person is not entitled.

(d) Any person found to be in violation of subsection (a), (b) or (c) of this section is guilty of a felony and, upon conviction, shall be imprisoned in a state correctional facility not less than one nor more than ten years, or shall be fined not to exceed $10,000 or both fined and imprisoned.

§9-7-5. Bribery; false claims; conspiracy; criminal penalties; failure to maintain records.

(a) A person shall not solicit, offer, pay, or receive any unlawful remuneration, including any kickback, rebate or bribe, directly or indirectly, with the intent of causing an expenditure of moneys from the medical services fund established pursuant to §9-4-2 of this code, which is not authorized by applicable laws or rules and regulations.

(b) A person shall not make or present or cause to be made or presented to the department a claim under the medical programs of the department knowing the claim to be false, fraudulent, or fictitious.

(c) A person shall not enter into an agreement, combination or conspiracy to obtain or aid another to obtain the payment or allowance of a false, fraudulent, or fictitious claim under the medical programs of the department.

(d) Any person found to be in violation of §9-7-5(a), §9-7-5(b) or §9-7-5(c) of this code is guilty of a felony and, upon conviction, shall be imprisoned in a state correctional facility not less than one nor more than 10 years or shall be fined not to exceed $10,000, or both fined and imprisoned.

(e) Any provider who, having submitted a claim for or received a benefit, payment, or allowance under the medical programs of the department, knowingly fails to maintain such records as are necessary to disclose fully the nature of a good or service for which a claim was submitted or benefit, payment, or allowance was received, or such records as are necessary to disclose fully all income and expenditures upon which rate of payment were based, for a period of at least five years following the date on which payment was received, shall be guilty of a misdemeanor and, upon conviction, may be imprisoned in a state correctional facility not to exceed one year or may be fined up to $1,000, or both fined and imprisoned. Any person who knowingly destroys such records within five years from the date the benefit, payment, or allowance was received, shall be guilty of a felony, and may be imprisoned in a state correctional facility not less than one nor more than 10 years or may be fined not to exceed $10,000, or both fined and imprisoned.

§9-7-5a. Venue for criminal offenses.

In addition to other venues permitted by state law, a criminal prosecution under section five of this article may be commenced in the circuit court of Kanawha County or of any county in which:

(a) The defendant is conducting business; or

(b) Any of the conduct constituting a violation of any provision of this article has occurred.

§9-7-6. Civil remedies; statute of limitations.

(a) Any person, firm, corporation, or other entity which makes or attempts to make, or causes to be made, a claim for benefits, payments, or allowances under the medical programs of the department, when the person, firm, corporation, or entity knows, or reasonably should have known, such claim to be false, fictitious, or fraudulent, or fails to maintain such records as are necessary shall be liable to the department in an amount equal to three times the amount of such benefits, payments, or allowances to which he or she or it is not entitled, and shall be liable for the payment of reasonable attorney fees and all other fees and costs of litigation.

(b) No criminal action or indictment need be brought against any person, firm, corporation, or other entity as a condition for establishing civil liability hereunder.

(c) A civil action under this section may be prosecuted and maintained on behalf of the department by the Attorney General, the Attorney General's assistants, or by any attorney in contract with or employed with the Office of the Attorney General to provide such representation. If the Attorney General declines to do so, the civil action shall be maintained either by a prosecuting attorney and the prosecuting attorney's assistants or by any attorney in contract with or employed by the department to provide such representation.

(d) Any civil action brought under this section shall be brought within five years from the time the false, fraudulent, or fictitious claim was made. Claims will be judged based on the Medicaid or program rules in existence at the time of the claim submission.

§9-7-6a. Liability of employees of the department; Office of the Attorney General.

There shall be no civil liability on the part of, and no cause of action shall arise against the department, the Office of the Attorney General, or employees or agents of the aforementioned for any action taken by them in good faith and in the lawful performance of their powers and duties under this article.

§9-7-7. Licensing of vehicles for use by the Medicaid fraud control unit.

For purposes of the responsibilities assigned the unit pursuant to this article, personnel of the unit shall be permitted to operate vehicles owned or leased for the state displaying Class A registration plates.

§9-7-8. Remedies and penalties not exclusive.

The remedies and penalties provided in this article governing the operation of the medical programs of the department are in addition to those remedies and penalties provided elsewhere by law.

§9-7-9. Severability.

If any provision of this article be found by a court of competent jurisdiction to be unenforceable under the Constitution of this state or the laws and Constitution of the United States, the remaining provisions of this article shall be deemed severable and shall continue in full force and effect.

§9-8-1. Definitions.

As used in this article:

"Able bodied adult" means a person between the ages of 18 and 49 years of age without dependents and who does not meet any of the exemptions set forth in §9-8-2(a) of this code.

"Applicant" or "recipient" means a person who is applying for, or currently receiving, public assistance in the State of West Virginia from the department.

"Department" means the Department of Human Services.

"Electronic benefit transfer" or "EBT" means any electronic system which allows the department to issue and track benefits via a magnetically encoded payment card.

"Good cause" means circumstances beyond the household's control, including, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, natural disaster, a declared state of emergency due to inclement weather, or the unavailability of transportation.

"Public assistance" means government benefits provided to qualifying individuals on the basis of need to provide basic necessities to individuals and their families. These shall include, but are not limited to, the following:

(A) Supplemental Nutrition Assistance Program, or SNAP;

(B) Medicaid; and

(C) Temporary Assistance to Needy Families, or TANF.

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

"Work" or "working" means:

(A) Work in exchange for money;

(B) Work in exchange for goods or services ("in kind" work);

(C) Unpaid work, verified under standards established by the department in rule; or

(D) Any combination thereof.

§9-8-2. Work requirements.

(a) All able bodied adults may receive Supplemental Nutrition Assistance benefits for only three months in each 36-month period. Recipients are exempt from the time limit if they are employed or are participating and complying with the requirements of a work, education, or volunteer program for at least 20 hours per week: Provided, That further exemptions may apply and shall be determined in accordance with federal law: Provided, however, That any such exemptions shall not exceed those granted by federal law.

(b) Beginning October 1, 2018, the department shall discontinue and shall not seek federal waivers granted pursuant to 7 U.S.C. § 2015(o) for Able Bodied Adults Without Dependents (ABAWD) for any county that cannot be demonstrated to have, through data in conformance with U.S. Bureau of Labor Statistics methodology set forth under federal law, a recent 12-month average unemployment rate above 10 percent; a recent 24-month average unemployment rate 20 percent above the national average for the same 24-month period; qualification for extended unemployment benefits; or designation as a "labor surplus area" by the U.S. Department of Labor. These waivers exempt able bodied adults with no children from work requirements for receipt of SNAP benefits. Notwithstanding any provision in this code to the contrary, all counties shall be ineligible for any such waiver effective October 1, 2022.

(c) The department shall submit a report to the Legislative Oversight Committee on Health and Human Resources Accountability, no later than October 1, 2020, on the employment impact of ABAWD requirements in those counties where they were implemented as of October 1, 2018. The report shall include, on a county-by-county basis, information on the number of SNAP recipients subject to work requirements; the number exempted from work requirements and the reasons for exemption; the number of applicants denied benefits due to non-compliance with work requirements; the dollar amount of benefits withheld due to non-compliance; the estimated fiscal impact on SNAP retailers of withholding those benefits; the number of recipients who engaged in work, education, or volunteerism in order to maintain benefits; the efforts made to assist recipients with meeting work requirements in order to maintain benefits; and any such recommendations pertaining to work requirements as the department deems advisable.

(d) If a recipient resides in a county subject to the provisions of this article, an applicant shall be deemed as complying with the requirements of a work, education, or volunteer program if any of the following requirements are satisfied:

(1) Working at least 20 hours per week, averaged monthly, or 80 hours a month;

(2) Participating in, and complying with, the requirements of a work force training program of 20 hours per week, as determined by the department in rule;

(3) Volunteering 20 hours a week, as determined by the department in rule;

(4) Any combination of working, volunteering and/or participating in a work program for a total of 20 hours per week, as determined by the department in legislative rule; or

(5) Participating in, and complying with, a workfare program as set out in 7 C.F.R. 273.24(a)(3).

(e) As determined by the department, if a recipient would have worked an average of 20 hours per week but missed some work for good cause, the recipient shall be considered to have met the work requirement if the absence from work is temporary and the recipient retains his or her job. Good cause includes circumstances beyond the household's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, natural disaster, a declared state of emergency due to inclement weather, or the unavailability of transportation.

(f) If the department determines that a waiver, or an amendment to a waiver, is necessary to implement a policy that complies with 7 C.F.R. 273.24, it shall request the waiver or the amendment to the waiver from the United States Department of Agriculture.

(g) The department shall propose legislative rules in accordance with the provisions of this code for a plan for implementation of the requirements set forth in this section in counties that are subject to the requirements set forth in §9-8-2 (d) of this code.

§9-8-3. Income and identity verification.

(a) By December 31, 2018, the department shall redesign an existing system or establish a new computerized income, asset, and identity eligibility verification system or contract with a third-party vendor to verify eligibility, eliminate the duplication of assistance, and deter waste, fraud, and abuse in each public assistance program which it administers.

(b) The department may contract with a third-party vendor to develop a system to provide a service or verify income, assets, and identity eligibility of applicants to prevent fraud, misrepresentation, and inadequate documentation when determining eligibility for public assistance. This system or service shall be accessed prior to determining eligibility, periodically between eligibility redeterminations, and during eligibility redeterminations and reviews. The department may contract with a vendor to provide information to facilitate reviews of recipient eligibility conducted by the department.

(c) A contract made pursuant to this section may not include a provision that provides the vendor with a monetary incentive for reducing the number of recipients.

(d) Nothing in this article precludes the department from continuing to conduct additional eligibility verification processes currently in practice.

§9-8-4. Eligibility verification.

All applications for benefits must be processed through a system as set forth in this article. Complete applications, including the interview, shall be processed within 10 days of receipt or the maximum period required by federal law. Prior to determining eligibility, the department shall access information for every applicant from federal, state, and other sources: Provided, That such access does not violate any federal law.

§9-8-5. Identity authentication.

(a) Prior to awarding public assistance, applicants for benefits must complete a computerized identity authentication process to confirm the identity of the applicant. This shall be done with a knowledge-based questionnaire consisting of financial and/or personal questions. The questionnaire must contain questions tailored to assist persons without a bank account or those who have poor access to financial and banking services or who do not have an established credit history. The questionnaire may be submitted online, in-person, or via telephone.

(b) The department shall submit a report to the Legislative Oversight Committee on Health and Human Resources Accountability regarding the feasibility of implementing the photo EBT card option under 7 U.S.C. § 2016(h)(9). The study shall address certain operational issues to ensure that state implementation would be consistent with all federal requirements, and that program access is protected for participating households, including, but not limited to, allowing the recipient to designate permitted users for purposes of utilizing the photo EBT card.

§9-8-6. Case review.

(a) If the information obtained from the review provided in this article does not result in the department finding a discrepancy or change in an applicant's or recipient's circumstances affecting eligibility, the department shall not take any further action and shall continue processing the application.

(b) If the review results in a discrepancy, the department shall promptly redetermine eligibility.

§9-8-7. Notice and right to be heard.

(a) An applicant shall be given written notice and the opportunity to explain any issues with the application or redetermination as set forth in §9-8-6 of this code. Self-declarations by applicants or recipients shall be accepted as verification of categorical and financial eligibility if no other verification source is available. In cases requiring expedited services an applicant's statement may be temporarily accepted until such time as verification is possible.

(b) The notice given to the applicant or recipient is required to describe the circumstances of the issue, the manner in which the applicant or recipient may respond, and the consequences of failing to take action. If the applicant does not respond timely as required by federal law, the department shall take appropriate action. The department may request additional information as it finds necessary to reach a decision.

(c) An individual may respond in writing, electronically, or verbally. If an individual responds verbally, staff shall note the time and contents of the response in the individual's file. The response by the individual may:

(1) Disagree with the findings of the department. The department shall reinvestigate the matter if the applicant or recipient disagrees. If the department finds that there has been an error, the department shall take immediate action to correct it. If the department determines that there is no error, the department shall determine the effect of the response on the applicant's or recipient's case and take appropriate action. Written notice of the department's action shall be given to the applicant or recipient; or

(2) Agree with the findings of the department. The department shall determine the effect on the applicant's or recipient's case and take appropriate action. Written notice of the department's action shall be given to the applicant or recipient.

(d) If the applicant fails to respond to the notice, the department shall deny or discontinue assistance for failure to verify information. Eligibility for assistance may not be established or reestablished until the issue has been resolved.

§9-8-8. Referrals for fraud, misrepresentation or inadequate documentation.

(a) After the case review as set forth in §9-8-6 of this code, the department shall refer cases of suspected fraud to the Office of Inspector General within the department. That office shall take appropriate action, including civil penalties or referral to an appropriate prosecuting attorney for criminal prosecution.

(b) In cases of substantiated fraud, upon conviction, the state shall review all appropriate legal options. These may include, but are not limited to, removal from other public assistance programs and garnishment of wages or state income tax refunds until the department recovers an equal amount of benefits fraudulently claimed.

(c) The department may refer suspected cases of fraud, misrepresentation, or inadequate documentation to appropriate agencies, divisions, or departments for review of eligibility issues in other public assistance programs. This should also include cases in which an individual is determined to be no longer eligible for the original program.

§9-8-9. Reporting to the Governor and Legislature.

The department shall prepare an annual report by January 15 each year to the Governor and Legislative Oversight Commission on Health and Human Resources Accountability. The report shall contain information on the effectiveness and general findings of the eligibility verification system, including the number of cases reviewed, the number of case closures, the number of referrals for criminal prosecution, recovery of improper payment, collection of civil penalties, the outcomes of cases referred to the Office of Inspector General, and any savings that have resulted from the system.

§9-8-10. Prohibitions on use of electronic benefit transfer cards.

(a) To ensure that public assistance program funds are used for their intended purposes, funds available on electronic benefit transfer cards may not be used to purchase alcohol, liquor or imitation liquor, cigarettes, tobacco products, bail, gambling activities, lottery tickets, tattoos, travel services provided by a travel agent, money transmission to locations abroad, sexually oriented adult materials, concert tickets, professional or collegiate sporting event tickets, or tickets for other entertainment events intended for the general public.

(b) Electronic benefit transfer card transactions are prohibited at all casinos, gaming establishments, tattoo parlors, massage parlors, body piercing parlors, spas, nail salons, lingerie shops, vapor cigarette stores, psychic or fortune-telling businesses, bail bond companies, video arcades, movie theaters, swimming pools, cruise ships, theme parks, dog or horse racing facilities, pari-mutuel facilities, sexually oriented businesses, retail establishments which provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment, and businesses or retail establishments where minors under age 18 are not permitted.

(c) Upon enrollment, the department shall provide all applicants with an itemized list of prohibited purchases, including those specified in this section, and make such list available on the department's website.

(d) If a recipient is found to have violated the provisions of this section, the department shall issue a warning in writing to the recipient. The recipient is subject to disqualification of benefits for up to three months following the first offense, for up to one year following the second offense, and a permanent termination of benefits following the third offense, unless expressly prohibited by federal law.

§9-8-11. Tracking out-of-state spending.

(a) The department shall post on its website and provide to the Joint Committee on Government and Finance a report of Supplemental Nutrition Assistance Program and Temporary Assistance for Needy Families benefit spending on or before January 15 of each year.

(b) The report required by this section shall include:

(1) The dollar amount and number of transactions of Supplemental Nutrition Assistance Program benefits that are accessed or spent out-of-state, by state;

(2) The dollar amount and number of transactions of Temporary Assistance for Needy Families benefits that are accessed or spent out-of-state, by state;

(3) The dollar amount, number of transactions and times of transactions of Supplemental Nutrition Assistance Program benefits that are accessed or spent in-state, by retailer, institution or location; and

(4) The dollar amount, number of transactions and times of Temporary Assistance for Needy Families transactions of benefits that are accessed or spent in-state, disaggregated by retailer, institution, or location.

(c) The report required pursuant to this section shall not identify individual recipients.

§9-8-12. Rulemaking.

The secretary may promulgate rules for legislative approval in accordance with the provisions of §29A-3-1 et seq. of this code which he or she finds necessary to effectuate the provisions of this article.

§9-9-1. Short title.

This article may be cited as the "WV Works Act".

§9-9-2. Legislative findings; purpose.

(a) The Legislature hereby finds and declares that:

(1) The entitlement of any person to receive federal-state cash assistance is hereby discontinued;

(2) At-risk families are capable of becoming self-supporting;

(3) An assistance program should both expect and assist a parent and caretaker-relatives in at-risk families to support their dependent children and children for which they are caretakers;

(4) Every parent or caretaker-relative can exhibit responsible patterns of behavior so as to be a positive role model;

(5) Every parent or caretaker-relative who receives cash assistance has a responsibility to participate in an activity to help them prepare for, obtain and maintain gainful employment;

(6) For a parent or caretaker-relative who receives cash assistance and for whom full-time work is not feasible, participation in some activity is required to further himself or herself, his or her family or his or her community;

(7) The state should promote the value of work and the capabilities of individuals;

(8) Job development efforts should enhance the employment opportunities of participants;

(9) Education is the key to achieving and maintaining life-long self-sufficiency; and

(10) An assistance program should be structured to achieve a clear set of outcomes; deliver services in an expedient, effective and efficient manner; and maximize community support for participants.

(b) The goals of the program are to achieve more efficient and effective use of public assistance funds; reduce dependency on public programs by promoting self-sufficiency; and structure the assistance programs to emphasize employment and personal responsibility. The success of the program is to be evaluated on the following activities, including, but not limited to, the following: Job entry, job retention, federal work participation requirements and completion of educational activities.

§9-9-3. Definitions.

In addition to the rules for the construction of statutes in section ten, article two, chapter two of this code and the words and terms defined in section two, article one of this chapter, unless a different meaning appears from the context:

(a) "At-risk family" means a group of persons living in the same household, living below the federally designated poverty level, lacking the resources to become self-supporting and consisting of a dependent minor child or children living with a parent, stepparent or caretaker-relative; an "at-risk family" may include an unmarried minor parent and his or her dependent child or children who live in an adult-supervised setting;

(b) "Beneficiary" or "participant" means any parent, work eligible individuals or caretaker-relative in an at-risk family who receives cash assistance for himself or herself and family members;

(c) "Caretaker-relative" means grandparents or other nonparental caretakers not included in the assistance group or receiving cash assistance directly;

(d) "Cash assistance" means temporary assistance for needy families;

(e) "Challenge" means any fact, circumstance or situation that prevents a person from becoming self-sufficient or from seeking, obtaining or maintaining employment of any kind, including physical or mental disabilities, lack of education, testing, training, counseling, child care arrangements, transportation, medical treatment or substance abuse treatment;

(f) "Community or personal development" means activities designed or intended to eliminate challenges to participation in self-sufficiency activities. These activities are to provide community benefit and enhance personal responsibility, including, but not limited to, classes or counseling for learning life skills or parenting, dependent care, job readiness, volunteer work, participation in sheltered workshops or substance abuse treatment;

(g) "Department" means the state Department of Human Services;

(h) "Education and training" means hours spent regularly attending and preparing for classes in any approved course of schooling or training;

(i) "Family assessments" means evaluation of the following: Work skills, prior work experience, employability, education and challenges to becoming self-sufficient such as mental health and physical health issues along with lack of transportation and child care;

(j) "Income" means money received by any member of an at-risk family which can be used at the discretion of the household to meet its basic needs: *Provided*, That income does not include:

(1) Supplemental security income paid to any member or members of the at-risk family;

(2) Earnings of minor children;

(3) Payments received from earned income tax credit or tax refunds;

(4) Earnings deposited in an individual development account approved by the department;

(5) Any educational grant or scholarship income regardless of source; or

(6) Any moneys specifically excluded from countable income by federal law;

(k) "Minor child head of household" means an emancipated minor under the age of eighteen years;

(l) "Nonrecipient parent" means an adult or adults excluded or disqualified by federal or state law from receiving cash assistance;

(m) "Personal responsibility contract" means a written agreement entered into by the department and a beneficiary for purposes of participation in the West Virginia Works Program;

(n) "Secretary" means the Secretary of the Department of Human Services;

(o) "Subsidized employment" means employment with earnings provided by an employer who receives a subsidy from the department for the creation and maintenance of the employment position;

(p) "Support services" includes, but is not limited to, the following services: Child care; Medicaid; transportation assistance; information and referral; resource development services which includes assisting families to receive child support and supplemental security income; family support services which includes parenting, budgeting and family planning; relocation assistance; and mentoring services;

(q) "Temporary assistance to needy families" is the federal program funded under Part A, Title IV of the Social Security Act, codified at 42 U.S.C. §601, et. seq.;

(r) "Transitional assistance" may include medical assistance, food stamp assistance, child care and supportive services as defined by the secretary and as funding permits;

(s) "Two-parent family" means two parents with a common child residing in the same household and included in a common West Virginia Works grant payment or, two parents with a common child residing in the same home and one or both of the parents are "work eligible individuals", as that term is defined in this section, but are excluded from the West Virginia Works payments unless the exclusion is due to an exemption as provided in section eight of this article.

(t) "Unsubsidized employment" means employment with earnings provided by an employer

who does not receive a subsidy from the department for the creation and maintenance of the employment position;

(u) "Vocational educational training" means organized educational programs, not to exceed twelve months for any individual, that are directly related to the preparation of individuals for employment in current or emerging occupations requiring training other than a baccalaureate or advance degree;

(v) "Work" means unsubsidized employment, subsidized employment, work experience, community or personal development and education and training;

(w) "Work eligible individual" means an adult or minor child head-of-household receiving assistance under the West Virginia Works Program or a nonrecipient parent living with a child receiving the assistance; and

(x) "Work experience" means a publicly assisted work activity, including work associated with the refurbishing of publicly assisted housing, performed in return for program benefits that provide general skills, training, knowledge and work habits necessary to obtain employment. This activity must be supervised daily and on an ongoing basis by an employer, work site sponsor or other responsible party.

§9-9-4. Authorization for program.

(a) The secretary shall conduct the WV works program in accordance with this article and any applicable regulations promulgated by the secretary of the federal department of health and human services in accordance with federal block-grant funding or similar federal funding stream. This program shall expend only the funds appropriated by the Legislature to establish and operate the program or any other funds available to the program; establish administrative due process procedures for reduction or termination proceedings; and implement any other procedures necessary to accomplish the purpose of this article.

(b) The WV works program authorized pursuant to this article does not create an entitlement to that program or any services offered within that program, unless entitlement is created pursuant to a federal law or regulation. The WV works program and each component of that program established by this article or the expansion of any component established pursuant to federal law or regulation is subject to the annual appropriation of funds by the Legislature.

(c) Copies of all rules proposed pursuant to authority granted in this article by the secretary shall be filed with the Legislative Oversight commission on health and human resources accountability established pursuant to article twenty-nine-e, chapter sixteen of this code.

§9-9-5. WV works program fund.

There is continued a special account within the state Treasury to be known as the "WV Works Program Fund". Expenditures from the fund shall be used exclusively to meet the necessary expenditures of the program, including wage reimbursements to participating employers, temporary assistance to needy families, payments for support services, employment-related child care payments, transportation expenses and administrative costs directly associated with the operation of the program. Moneys paid into the account shall be from specific annual appropriations of funds by the Legislature.

§9-9-6. Program participation.

(a) Unless otherwise noted in this article, all adult beneficiaries of cash assistance and work eligible individuals shall participate in the West Virginia Works Program in accordance with the provisions of this article. The level of participation, services to be delivered and work requirements shall be defined through legislative rules established by the secretary.

(b) Any individual exempt under the provisions of section eight of this article may participate in the activities and programs offered through the West Virginia Works Program.

(c) Support services other than cash assistance through the West Virginia Works Program may be provided to at-risk families to assist in meeting the work requirements or to eliminate the need for cash assistance.

(d) Cash assistance through the West Virginia Works Program may be provided to an at-risk family if the combined family income, as defined in section three of this article, is below the income test levels established by the department, subject to the following:

(1) Any adult member of an at-risk family who receives supplemental security income shall be excluded from the benefit group;

(2) Within the limits of funds appropriated therefor, an at-risk family that includes a married man and woman and dependent children of either one or both may receive an additional cash assistance benefit in an amount of $100 or less; and

(3) An at-risk family shall receive an additional cash assistance benefit in the amount of $25 regardless of the amount of child support collected in a month on behalf of a child or children of the at-risk family, as allowed by federal law.

§9-9-7. Work requirements.

(a) Unless otherwise exempted by the provisions of section eight of this article, the West Virginia Works Program shall require that anyone who possesses a high school diploma, or its equivalent, or anyone who is of the age of twenty years or more, to work or attend an educational or training program for at least the minimum number of hours per week required by federal law under the work participation rate requirements for all families in order to receive any form of cash assistance. Participation in any education or training activity, as defined in section three of this article, shall be counted toward satisfaction of the work requirement imposed by this section to the extent permissible under federal law and regulation: Provided, That the participant demonstrates adequate progress toward completion of the program. In accordance with federal law or regulation, the work, education and training requirements of this section are waived for any qualifying participant with a child under six years of age if the participant is unable to obtain appropriate and available child care services.

(b) The department and representatives of the Higher Education Policy Commission and the West Virginia Council for Community and Technical College Education shall develop and implement a plan to use and expand the programs available at the state's community and technical colleges, colleges and universities to assist beneficiaries or participants who are enrolled or wish to become enrolled in vocational-educational training not to exceed twelve months with respect to any individual to meet the work requirements of this section. Vocational-educational training shall be supervised daily and on an ongoing basis.

§9-9-8. Exemptions.

The secretary shall establish by rule categories of persons exempt, but the exemption applies only to the work requirements of the program: Provided, That a person who is exempt from the work requirements may nevertheless participate voluntarily in work activities. The categories of exemptions are limited to the following:

(1) Undocumented aliens and aliens under the five-year ban;

(2) Parents, or at state option on a case-by-case basis, anyone receiving supplemental security income;

(3) A parent who is providing medically necessary care for a disabled family member who resides in the home and is not a full-time student;

(4) Minor parents who are not head of household (spouses of the head of household); and

(5) Grandparents and other nonparental caretakers.

§9-9-9. Personal responsibility contract.

(a)(1) Every eligible adult beneficiary and work eligible individual shall participate in a program orientation, family assessments and in the development, and subsequent revisions, of a personal responsibility contract. The contract shall be defined based on the program time limits, support services available, work requirements and family assessments.

(2) The participant's contract shall include the following requirements:

(A) That the participant develop and maintain, with the appropriate health care provider, a schedule of preventive care for his or her dependent child or children, including routine examinations and immunizations;

(B) Assurance of school attendance for school-age children under his or her care;

(C) Assurance of properly supervised child care, including after-school care;

(D) Establishment of paternity or active pursuit of child support, or both, if applicable and if considered necessary; and

(E) Nutrition or other counseling, parenting or family-planning classes.

(3) If the participant is a teenage parent, he or she may work, but the contract shall include the requirements that the participant:

(A) Remain in an educational activity to complete high school, obtain a general equivalency diploma or obtain vocational training and make satisfactory scholastic progress;

(B) Attend parenting classes or participate in a mentorship program, or both, if appropriate; and

(C) Live at home with his or her parent or guardian or in some other adult-supervised arrangements if he or she is an unemancipated minor.

(4) If the participant is under the age of twenty years and does not have a high school diploma or its equivalent, the contract shall include requirements to participate in mandatory education or training which, if the participant is unemployed, may include a return to high school, with satisfactory scholastic progress required.

(b) In order to receive cash assistance, the participant shall enter into a personal responsibility contract. If the participant refuses to sign the personal responsibility contract, the participant and family members are ineligible to receive cash assistance: Provided, That a participant who alleges that the terms of a personal responsibility contract are inappropriate based on his or her individual circumstances may request and shall be provided a fair and impartial hearing in accordance with administrative procedures established by the department and due process of law. A participant who signs a personal

responsibility contract or complies with a personal responsibility contract does not waive his or her right to request and receive a hearing under this subsection.

(c) Personal responsibility contracts shall be drafted by the department on a case-by-case basis; take into consideration the individual circumstances of each beneficiary; reviewed and reevaluated periodically, but not less than on an annual basis; and, in the discretion of the department, amended on a periodic basis.

§9-9-10. Participation limitation; exceptions.

The length of time a participant may receive cash assistance through the WV works program may not exceed a period longer than sixty months, except in circumstances as defined by the secretary.

§9-9-11. Breach of contract; notice; sanctions.

(a) The department may terminate cash assistance benefits to an at-risk family if it finds any of the following:

(1) Fraud or deception by the beneficiary in applying for or receiving program benefits;

(2) A substantial breach by the beneficiary of the requirements and obligations set forth in the personal responsibility contract and any amendments or addenda to the contract; or

(3) A violation by the beneficiary of any provision of the personal responsibility contract or any amendments or addenda to the contract, this article, or any rule or policy promulgated by the secretary pursuant to this article.

(b) In the event the department determines that benefits received by the beneficiary are subject to reduction or termination, written notice of the reduction or termination and the reason for the reduction or termination shall be deposited in the United States mail, postage prepaid and addressed to the beneficiary at his or her last-known address at least thirteen days prior to the termination or reduction. The notice shall state the action being taken by the department and grant to the beneficiary a reasonable opportunity to be heard at a fair and impartial hearing before the department in accordance with administrative procedures established by the department and due process of law.

(c) In any hearing conducted pursuant to the provisions of this section, the beneficiary has the burden of proving that his or her benefits were improperly reduced or terminated and shall bear his or her own costs, including attorneys' fees.

(d) The secretary shall promulgate emergency rules and propose for legislative promulgation legislative rules, pursuant to article three, chapter twenty-nine-a of this code, setting forth the schedule of sanctions to be imposed when a beneficiary has violated any provision of this article, of his or her personal responsibility contract or any amendment or addendum to the contract, or any applicable department rule. In developing these rules, the secretary is directed to make those sanctions graduated and sufficiently stringent, when compared to those of contiguous states, so as to discourage persons from moving from such states to this state to take advantage of lesser sanctions being imposed for the same or similar violations by the secretary. The secretary shall also promulgate legislative rules setting forth what constitutes de minimis violations and those violations subject to sanctions and maximum penalties.

(e) The department shall provide an annual report regarding the sanctions relating to the Temporary Assistance to Needy Families program , including their relative stringency when compared to those of contiguous states, frequency of imposition and the overall success of those sanctions at deterring individuals from taking advantage of the Temporary Assistance to Needy Families program and accomplishing the overall purposes of the program, to the Legislative Oversight Commission on Health and Human Resources Accountability on

January 1 of each year. Copies of that report shall also be furnished to the President of the Senate and Speaker of the House.

§9-9-12. Diversionary assistance allowance in lieu of monthly cash assistance.

(a) In order to encourage at-risk families not to apply for ongoing monthly cash assistance from the state, the secretary may issue one-time diversionary assistance allowances to families in an amount not to exceed the equivalent of three months of cash assistance in order to enable the families to become immediately self-supporting.

(b) The secretary shall establish by rule the standards to be considered in making diversionary assistance allowances.

(c) Nothing in this section may be construed to require that the department or any assistance issued pursuant to this section be subject to any of the provisions of chapter thirty-one or chapter forty-six-a of this code.

§9-9-13. Subsidized employment.

(a) To the extent that resources are available, an employer may be paid a subsidy by the department to employ a parent or caretaker-relative of an at-risk family if the employer agrees to hire the WV works program participant at the end of the subsidized period. If the employer does not hire the participant at the end of the subsidized period, the program may not use that employer for subsidized employment for the next twelve months.

(b) If the department determines that an employer has demonstrated a pattern of discharging employees hired pursuant to the provisions of this section subsequent to the expiration of the subsidized period without good cause, the employer shall no longer be eligible for participation in the subsidized employment program for a period to be determined by the department.

§9-9-14. Transitional assistance.

The WV works program may provide transitional assistance in the form of supportive services.

§9-9-15. Interagency coordination.

The Legislature encourages the development of a system of coordinated services, shared information and streamlined application procedures between the program and the other agencies within the department to implement the provisions of this article. The secretary shall require the coordination of activities between the program and the following agencies:

(a) The child support enforcement division for the purpose of establishing paternity, promoting cooperation in the pursuit of child support, encouraging noncustodial parents to get job search assistance and determining eligibility for cash assistance and support services;

(b) The bureau of public health for the purpose of determining appropriate immunization schedules, delivery systems and verification procedures; and

(c) The bureau of medical services for the purpose of reporting eligibility for medical assistance and transitional benefits.

The secretary may require the coordination of procedures and services with any other agency he or she considers necessary to implement this program: Provided, That all agencies coordinating services with the department shall, when provided with access to department records or information, abide by state and federal confidentiality requirements including the provisions of section twenty of this article.

The secretary shall propose any rules, including emergency rules, necessary for the coordination of various agency activities in the implementation of this section.

§9-9-16. Intergovernmental coordination.

(a) The commissioner of the Bureau of Employment Programs and the superintendent of the Department of Education shall assist the secretary in the establishment of the WV works program. Before implementation of this program, each department shall address in its respective plan the method in which its resources will be devoted to facilitate the identification of or delivery of services for participants and shall coordinate its respective programs with the department in the provision of services to participants and their families. Each county board of education shall designate a person to coordinate with the local Department of Human Services office the board's services to participant families and that person shall work to achieve coordination at the local level.

(b) The secretary and the superintendent shall develop a plan for program implementation to occur with the use of existing state facilities and county transportation systems within the project areas whenever practicable. This agreement shall include, but not be limited to, the use of buildings, grounds and buses. Whenever possible, the supportive services, education and training programs should be offered at the existing school facilities.

(c) The commissioner shall give priority to participants of the WV works program within the various programs of the Bureau of Employment Programs. The secretary and the commissioner shall develop reporting and monitoring mechanisms between their respective agencies.

§9-9-17. Public-private partnerships.

The secretary may enter into agreements with any private, nonprofit, charitable or religious organizations to promote the development of the community support services necessary for the effective implementation of this program, including cooperative arrangements with private employers of former program participants for the purpose of obtaining and maintaining employer-based family health insurance coverage for former participants and their spouses and dependent children through direct payments to the employers out of funds appropriated for the cooperative agreements.

§9-9-18. Relationship with other law.

If any provision of this article conflicts with any other provision of this code or rules, the provisions of this article shall supersede such provisions: Provided, That the provisions of this article shall not supersede any provisions which are required or mandated by federal law.

Any reference in this code or rules to "aid to families with dependent children" means "temporary assistance for needy families" or any successor state program funded under Part A, Title IV of the Social Security Act.

§9-9-19. Legislative oversight.

The Legislative Oversight commission on health and human resources accountability is charged with immediate and ongoing oversight of the program created by this article. This commission shall study, review and examine the work of the program, the department and its staff; study, review and examine all rules proposed by the department; and monitor the development and implementation of the WV works program. The commission shall review and make recommendations to the Legislature and the legislative rule-making review committee regarding any plan, policy or rule proposed by the secretary, the department or the program.

§9-9-20. Confidentiality, fines and penalties.

(a) Except as otherwise provided in this code or rules, all records and information of the department regarding any beneficiary or beneficiary's family members, including food stamps, child support and Medicaid records, are confidential and shall not be released, except under the following circumstances:

(1) If permissible under state or federal rules or regulations;

(2) Upon the express written consent of the beneficiary or his or her legally authorized representative;

(3) Pursuant to an order of any court of record of this state or the United States based upon a finding that the information is sufficiently relevant to a proceeding before the court to outweigh the importance of maintaining the confidentiality established by this section: Provided, That all confidential records and information presented to the court shall after review be sealed by the clerk and shall not be open to any person except upon order of the court upon good cause being shown for the confidential records and information to be opened; or

(4) To a department or division of the state or other entity, pursuant to the terms of an interagency or other agreement: Provided, That any agreement specifically references this section and extends its requirements for confidentiality to the other entity receiving the records or information, its agents and employees.

(b) Any person who knowingly and willfully releases or causes to be released the confidential records and information described in this section, except under the specific circumstances enumerated in this section, is guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $500 or confined in the county or regional jail for not more than six months, or both.

§9-9-21. West Virginia Works Separate State College Program; eligibility; special revenue account.

(a) There is established the West Virginia Works Separate State College Program. The program shall provide funding for participants who are enrolled in post-secondary courses leading to a two- or four-year degree. There is created within the state Treasury a special revenue account to be known as the West Virginia Works Separate State College Program Fund. Expenditures from the fund shall be for the purposes set forth in this section and are not authorized from collections but are to be made only in accordance with appropriations by the Legislature and in accordance with the provisions of article three, chapter twelve of this code and upon fulfillment of the provisions of article two, chapter eleven-b of this code. Necessary expenditures include wage reimbursements to participating employers, temporary assistance to needy families, payments for support services, employment-related child care payments, transportation expenses and administrative costs directly associated with the operation of the program.

(b) All eligible adults attending post-secondary courses leading to a two- or four-year degree and who are not participating in vocational education training, as that term is defined in this article, shall be enrolled in the West Virginia Works Separate State College Program. Participants in the program shall not be required to engage in more than ten hours per week of federally defined work activities. The work, education and training requirements of this article are waived for any qualifying participant with a child under six years of age if the participant is unable to obtain appropriate and available child care services. All other requirements of West Virginia Works apply to program administration for adults enrolled in the program.

(c) The Department of Human Services shall work with the Higher Education Policy Commission, as set forth in article one-b, chapter eighteen-b of this code, and the Council for Community and Technical College Education, as set forth in article two-b, chapter eighteen-b of this code, to develop and implement a plan to use and expend funds for the programs available at the state's community and technical colleges and colleges and universities to assist participants who are enrolled, or wish to become enrolled, in two- and four-year degree programs of post-secondary education to meet the work requirements of this article.

§9-9-22. West Virginia Works Separate State Two-Parent Families Program.

(a) There is established the West Virginia Works Separate State Two-Parent Families Program. The program shall provide funding for participants who are a two-parent family as that term is defined in this article. There is created within the state Treasury a special revenue account to be known as the West Virginia Works Separate State Two-Parent Program Fund. Expenditures from the fund shall be for the purposes set forth in this section and are not authorized from collections but are to be made only in accordance with appropriations by the Legislature and in accordance with the provisions of article three, chapter twelve of this code and upon fulfillment of the provisions of article two, chapter eleven-b of this code. Necessary expenditures include wage reimbursements to participating employers, temporary assistance to needy families, payments for support services, employment-related child care payments, transportation expenses and administrative costs directly associated with the operation of the program.

(b) All eligible two parent families, as that term is defined in this article, shall enroll in the West Virginia Works Separate State Two-Parent Families Program. All requirements of West Virginia Works shall apply to program administration for two-parent families enrolled in the program.

§9-10-1. Definitions.

As used in this article, the term:

(1) "Secretary" means the Secretary of the West Virginia Department of Human Services or his or her designee.

(2) "Fund" means the West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund.

(3) "Traumatic brain injury" means an acquired injury to the brain, including brain injuries caused by anoxia due to near drowning. "Traumatic brain injury" does not include brain dysfunction caused by congenital or degenerative disorders, nor birth trauma.

(4) "Spinal cord injury" means a traumatic injury to the spinal cord that results in a permanent loss of sensation and voluntary movement below the level of the lesion.

§9-10-2. Fund continued under department.

(a) The special revenue account in the State Treasury known as the "West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund," which was previously authorized by §18-10K-1 *et seq*. of this code, is continued.

(b) All powers and duties of the West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund Board are transferred to the Secretary.

(c) All powers and duties of the West Virginia Division of Rehabilitation Services related to administration of the West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund are transferred to the Secretary.

§9-10-3. Administration of Fund; administrative fees; Fund use.

(a) The West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund is subject to the annual appropriation of funds by the Legislature. The West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund may receive any gifts, grants, contributions or other money from any source which is specifically designated for deposit in the Fund.

(b) All moneys collected, received and deposited into the State Treasury and credited to the West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund shall be expended by the Secretary exclusively in accordance with the uses and criteria set forth in this article. Expenditures from this Fund for any other purposes are void.

(c) The Fund shall be administered by the Department of Human Services: *Provided*, That the Department may not charge a fee to administer the Fund.

(d) Nothing in this article may be construed to mandate funding for the Fund or to require any appropriation by the Legislature.

(e) Moneys in the Fund shall be used to pay for services that will increase opportunities for and enhance the achievement of functional independence, and a return to a productive lifestyle for individuals who have suffered a traumatic brain injury or a spinal cord injury.

(f) Services that are eligible for payment by the Fund shall include, but not be limited to:

(1) Case management;

(2) Rehabilitative therapies and services;

(3) Attendant care;

(4) Home accessibility modifications;

(5) Equipment necessary for activities; and

(6) Family support services.

(g) Funds shall be expended according to the priorities and criteria for disbursement established by the secretary under section four of this article, and pursuant to legislative rules authorized in section five of this article.

§9-10-4. Criteria and priorities for use of Fund.

(a) The Secretary shall establish priorities and criteria for the disbursement of moneys in the Fund by conducting at least one annual public meeting in each of the state's three congressional districts in existence on January 1, 2018, to identify the needs of citizens with traumatic brain injuries and spinal cord injuries, and to identify the gaps in services to these citizens. Public meetings held pursuant to the requirements of this section shall be noticed and advertised as public meetings, and the Secretary shall accept public comments for not less than thirty days following each public meeting.

(b) On or before December 31 of each year the Secretary shall issue an annual report to the Governor and to the Legislative Oversight Commission on Health and Human Resources Accountability, with recommendations for meeting the identified needs within the existing programs, proposing statutory changes to facilitate the delivery of services, improving coordination of services and summarizing its actions during the preceding year.

(c) Moneys expended for services described under section three of this article shall be as a payer of last resort and only for citizens of this state. An individual shall use comparable benefits and services that are available prior to the expenditure of moneys available to that individual through the Fund.

§9-10-5. Promulgation of legislative rules.

(a) The Secretary may propose legislative rules for promulgation, in accordance with the provisions of §29A-3-1 et seq. of this code, necessary for the transaction of its business or to carry out the purposes of this article. The rules shall include priorities and criteria for the disbursement of moneys in the Fund.

(b) The rules of the West Virginia Traumatic Brain and Spinal Cord Injury Rehabilitation Fund Board previously promulgated pursuant to section three, §18-10K-1 et seq. of this code shall remain in force and effect until the promulgation of new or additional rules by the Secretary.

§9-10-6. Legislative Audit.

[Repealed]