WEST VIRGINIA LEGISLATURE
SECOND EXTRAORDINARY SESSION, 1991

ENROLLED
Comm. Sub. for
HOUSE BILL NO. 210

(By Delegate Mr. Speaker, Mr. Chambers)
[By Request of the Executive]

Passed October 18, 1991

In Effect From Passage
AN ACT to amend chapter nine of the code of West Virginia, one thousand nine hundred thirty-one, as amended, by adding thereto two new articles, designated articles four-b and four-c; and to amend chapter eleven of said code by adding thereto a new article, designated article twenty-six, all relating to medicaid enhancement; definitions; creating physician provider medicaid enhancement board, general medicaid enhancement board, dentist provider medicaid enhancement board, ambulance service provider medicaid enhancement board and outpatient hospital medicaid enhancement board; expenses for board members; powers and duties of boards; participation and report by health care cost review authority with respect to regulation and rates of ambulance services; creating special revenue accounts for purposes of medicaid enhancement; effective date; termination date of boards; allowing for enhanced reimbursement to providers; abrogation; duties of the secretary of the department of health and human resources; legislative findings; levying a health care provider medicaid enhancement tax assessed against medicaid reimbursements of health care providers; procedures for collecting and administering tax; crimes
and penalties; and dedicating proceeds of tax for purposes of medicaid enhancement.

Be it enacted by the Legislature of West Virginia:

That chapter nine of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended by adding thereto two new articles, designated articles four-b and four-c; and that chapter eleven of said code be amended by adding thereto a new article, designated article twenty-six, all to read as follows:

CHAPTER 9. HUMAN SERVICES.

ARTICLE 4B. PHYSICIAN PROVIDER MEDICAID ENHANCEMENT ACT.

§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 provider medicaid enhancement board created to develop, review, and recommend the physician provider fee schedule.

(b) "Cost-based services" means any service delivered by a physician provider reimbursed under the medical assistance program of this state solely on the basis of costs reported to the single state agency, whether or not the provider operates on a profit or not for profit basis.

(c) "Fund" means the physician provider medicaid enhancement fund established to receive moneys collected from physician providers, individuals and corporations which will be matched with federal medicaid funds pursuant to Title XIX of the United States Social Security Act and expended in accordance with the provisions of this article.

(d) "Physician provider" means an allopathic or osteopathic physician, physician assistant, nurse-midwife, nurse anesthetist or advanced practice nurse, regardless of location, enrolled with the single state agency, rendering services within or without 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,
from this state under the medical assistance program of
the Social Security Act: Provided, That this definition
does not include a physician provider to the extent that
such person renders cost-based services.

(c) "Secretary" means the secretary of the department
of human resources.

(f) "Single state agency" means the single state agency
for medicaid in this state.

§9-4B-2. Physician provider medicaid enhancement
board; creation and composition.

There is hereby created the West Virginia physician
provider medicaid enhancement board to consist of
seven members. The board shall consist of six 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 four allopathic physicians, one osteopathic
physician and one lay person. The governor shall select
the allopathic physician members from a list of eight
recommendations submitted to the governor by the state
medical association, the osteopathic physician board
member from three recommendations submitted to the
governor by the state osteopathic society, 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 recommenda-
tions. 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
the first day of July, one thousand nine hundred ninety-
four. The board shall select a member to act as
chairperson. The chairperson shall be the chief adminis-
trative officer and shall preside over official transac-
ton 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.


(a) The board shall:

(1) Develop and recommend a reasonable physician provider fee schedule so that the schedule conforms to the greatest extent possible to usual and customary charges in accordance with federal Medicaid laws. In developing the fee schedule, the board shall refer to a nationally published fee schedule selected by the secretary of the department of health and human resources. Upon approval by the single state agency, the single state agency shall implement the physician provider fee schedule. If the single state agency does not approve of the fee schedule as developed by the board, then the board may submit a report to the Legislature including its recommendations and any other information necessary;

(2) Review the fee schedule on a quarterly basis and recommend to the single state agency any adjustments it considers necessary. The single state agency may approve the board's recommendations and implement the adjustments;

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

(4) Assist and enhance communications between participating physician providers and the department of health and human resources; and

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

(b) The board may receive and transmit to the fund, private funds contributed, donated or bequeathed by corporations, individuals or other entities as contem-
(c) The board may carry out any other powers and duties as prescribed for it by the secretary.

(d) 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. 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.

§9-4B-5. Physician provider Medicaid enhancement fund.

(a) There is hereby created in the State treasury a special revenue account, which shall be an interest-bearing account, known as the physician provider Medicaid enhancement fund. All taxes, additions to tax, penalties and interest collected from physician providers in accordance with Article Twenty-six, Chapter Eleven of this Code, all donations and contributions received by the board in accordance with Section Four of this article, and all interest earned by reason of investment of fund money deposited in the fund, shall be deposited into the fund and shall be used exclusively for the following purposes:

(1) To increase physician provider Medicaid reimbursement adopted by the single state agency through recommendations by the board;

(2) To cover the costs of increased utilization due to program growth; and

(3) To cover administrative costs.

(b) Any balance remaining in the fund at the end of any state fiscal year shall not revert to the general revenue fund but shall remain in the fund and shall be used solely in a manner consistent with this article.

(c) Moneys received into the fund shall not be credited as part of the general appropriation by the Legislature.
§9-4B-6. Amount and remittance of reimbursement.

Any physician provider required to pay a tax in accordance with article twenty-six, chapter eleven of this code, is entitled to receive enhanced medicaid reimbursements in an amount which, at a minimum, is equal to the amount of the tax paid by the individual taxpayer for the taxable year (exclusive of additions to tax, penalties or interest), plus three percent.

§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 the first day of January, one thousand nine hundred ninety-two.


(a) This article abrogates and is of no further force and effect, without any further action required by the Legislature, upon the earliest of the following dates:

(1) The date upon which an act of Congress becomes effective prohibiting the inclusion of revenue from provider taxes when determining the amount of state expenditures that are claimable as medical assistance for purposes of obtaining federal matching dollars: Provided, That if such act specifies a later date on which such prohibition takes effect, that later effective date controls;

(2) The date upon which a judgment or order of a court of competent jurisdiction becomes final prohibiting the inclusion of revenue from provider taxes when determining the amount of state expenditures that are claimable as medical assistance for purposes of obtaining federal matching dollars: Provided, That if such judgment or order specifies a later date on which the prohibition takes effect, that later effective date controls;

(3) The date upon which the Legislature appropriates the proceeds from the tax levied under article twenty-six, chapter eleven of this code, for any purpose not in
conformity with this article;

(4) The date upon which any federal administrative rule or regulation promulgated in conformity with federal law becomes effective which negates the effect or purpose of this article: Provided, That if such federal rule or regulation specifies a later date on which the prohibition takes effect, that later effective date controls; or

(5) The first day of July, one thousand nine hundred ninety-four.

(b) Upon abrogation of this article, the single state agency shall use the moneys remaining in the fund to maintain, to the greatest extent possible, the increased fee schedule as determined by the single state agency. Thereafter, the single state agency shall distribute any moneys insufficient to maintain the increased fee schedule on a proportional basis among all participating providers, from the fund, as determined by the secretary.

(c) Upon abrogation, the medicaid reimbursement levels shall return to those amounts in existence on the thirty-first day of December, one thousand nine hundred ninety-one.

ARTICLE 4C. HEALTH CARE PROVIDER MEDICAID ENHANCEMENT ACT.

§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, regardless of location, enrolled with the single state agency, rendering ambulance services within or without 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, from this state under the medical assistance program of the Social Security Act: Provided, That this definition does not include an ambulance service
(b) "Cost-based service" means any service reimbursed under the medical assistance program of this state solely on the basis of costs reported to the single state agency, whether or not such service is rendered on a profit or not for profit basis.

(c) "Dentist provider" means a dentist, regardless of location, enrolled with the single state agency, rendering services within or without 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, from this state under the medical assistance program of the Social Security Act: Provided, That this definition does not include a dentist provider to the extent that such person renders cost-based services.

(d) "General health care provider" means an optometrist, an optician, an audiologist, a podiatrist, a chiropractor, a psychologist, a person providing medical equipment and supply services, a person providing laboratory services, a person providing radiology services, a speech therapist, an occupational therapist, a physical therapist, a behavioral health center, or a local health department, regardless of location, enrolled with the single state agency, rendering services within or without 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, from this state under the medical assistance program of the Social Security Act: Provided, That this definition does not include a general health care provider to the extent that such person renders cost-based services.

(e) "Outpatient hospital service provider" means a person, regardless of location, enrolled with the single state agency, rendering outpatient hospital services within or without 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, from this state under the medical assistance program of the Social Security Act: 

*Provided, That this definition does not include an outpatient hospital service provider to the extent that such person renders cost-based services.*

(f) "Secretary" means the secretary of the department of health and human resources.

(g) "Single state agency" means the single state agency for medicaid in this state.

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

There is hereby created the general medicaid enhancement board to consist of seventeen members. Sixteen members shall be appointed by the governor, including two lay persons and one representative from each of the following fourteen groups: Chiropractors, optometrists, opticians, audiologists, podiatrists, psychologists, medical equipment and supply services, laboratory services, radiology services, speech therapists, occupational therapists, physical therapists, behavioral health centers and local health departments. In addition to the sixteen members appointed by the governor, the secretary, or his or her designee, shall serve as an ex officio, nonvoting member of the board. The governor shall make all appointments within twenty days from 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, shall be made in the same manner as the initial appointment, and the terms of all members expire on the first day of July, one thousand nine hundred ninety-four.

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

There is hereby created 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 the first day of July, one thousand nine hundred ninety-four.

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

There is hereby created 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 the first day of July, one thousand nine hundred ninety-four.

§9-4C-5. Outpatient hospital medicaid enhancement board.

There is hereby created the outpatient hospital medicaid enhancement board to consist of seven members. In order to carry out the purpose of this article, the board shall represent outpatient hospital service providers. The board shall consist of five representatives of outpatient hospital service providers, one lay person and the secretary, or his or her designee who shall serve as an ex officio, nonvoting member. The secretary shall select the outpatient hospital service provider members from ten recommendations submit-
ted by the West Virginia hospital association and the lay person at his or her discretion. The West Virginia hospital association shall submit all recommendations to the secretary within five days of the effective date of this article and the secretary 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 the first day of July, one thousand nine hundred ninety-four.

§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 and recommend a reasonable provider fee schedules, in relation to its respective provider group, so that the schedule conforms, to the greatest extent possible, to usual and customary charges in accordance with federal medicaid laws. In developing the fee schedule the board shall refer to a nationally published fee schedule, if available, as selected by the secretary in accordance with section eight of this article. Upon approval by the single state agency, the single state agency shall implement the provider fee schedule. If the single state agency does not approve of the fee schedule as developed by the board, then the board may submit a report to the Legislature along with its recommendations and any other information necessary;

(2) Review its respective provider fee schedule on a quarterly basis and recommend to the single state agency any adjustments it considers necessary. The single state agency may approve a board's recommendations and implement the adjustments;
(3) Assist and enhance communications between participating providers and the department of health and human resources;

(4) Meet and confer with representatives from each specialty area within its respective provider group so that equity in reimbursement increases 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 receive and transmit to its respective fund, private moneys contributed, donated or bequeathed by corporations, individuals or other entities as contemplated and permitted by applicable federal medicaid laws.

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

(d) 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. 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.

(e) In addition to the duties specified in subsection (a) of this section, the ambulance service provider medicaid enhancement board shall work with the health care cost review authority to develop a method for regulating rates charged by ambulance services. The health care cost review authority shall report its findings to the Legislature by the first day of January, one thousand nine hundred ninety-three. The costs of the report shall be paid by the health care cost review authority. In this capacity only, the chairperson of the health care cost review authority shall serve as an ex officio, nonvoting member of the board.

§9-4C-8. Duties of secretary of department of health and human resources.
(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 cooperate with the health care cost review authority to 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 for the health care cost review authority 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. Provider medicaid enhancement funds.

(a) There are hereby created in the state treasury special revenue accounts, which shall be interest bearing accounts, designated as the following:

1. General medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected in accordance with article twenty-six, chapter eleven of this code, from general health care providers, all donations and contributions received by the general medicaid enhancement board in accordance with section seven of this article, and all interest earned from the investment of moneys deposited into the fund, shall be deposited into this fund;
(2) The outpatient hospital medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected from outpatient hospital providers in accordance with article twenty-six, chapter eleven of this code, all donations and contributions received by the outpatient hospital medicaid enhancement board in accordance with section seven of this article, and all interest earned from the investment of moneys deposited into the fund, shall be deposited into this fund;

(3) The dentist provider medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected from dentist providers in accordance with article twenty-six, chapter eleven of this code, all donations and contributions received by the dentist provider medicaid enhancement board in accordance with section seven of this article, and all interest earned from the investment of moneys deposited into the fund, shall be deposited into this fund; and

(4) The ambulance service provider medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected from ambulance service providers in accordance with article twenty-six, chapter eleven of this code, all donations and contributions received by the ambulance service provider medicaid enhancement board in accordance with section seven of this article, and all interest earned from the investment of moneys deposited into the fund, shall be deposited into this fund.

(b) All proceeds from the medicaid enhancement funds shall be used exclusively for the following purposes:

(1) To increase health care provider medicaid reimbursement adopted by the single state agency through recommendations by the boards;

(2) To cover the costs of increased utilization due to program growth; and

(3) To cover administrative costs.

(c) Any balance remaining in the funds at the end of any state fiscal year shall not revert to the general revenue fund but shall remain in the funds and shall be
§9-4C-10. Amount and remittance of reimbursement.

Any general health care provider, dentist provider, ambulance service provider, or outpatient hospital service provider required to pay tax in accordance with article twenty-six, chapter eleven of this code, is entitled to receive enhanced medicaid reimbursements in an amount which, at a minimum, is equal to the tax paid by the individual taxpayer for the taxable year (exclusive of additions to tax, penalties or interest), plus three percent.

§9-4C-11. Effective date.

The provider fee schedules as adopted by the single state agency through recommendations by each board become effective on the first day of January, one thousand nine hundred ninety-two: 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. Abrogation.

(a) This article abrogates and is of no further force and effect, without any further action by the Legislature, upon the earliest of the following dates:

(1) The date upon which an act of Congress becomes effective prohibiting the inclusion of revenue from provider taxes when determining the amount of state expenditures that are claimable as medical assistance for purposes of obtaining federal matching dollars: Provided, That if such act specifies a later date on which such prohibition takes effect, that later effective date controls;

(2) The date upon which a judgment or order of a court of competent jurisdiction becomes final prohibit-
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14 ing the inclusion of revenue from provider taxes when
determining the amount of state expenditures that are
claimable as medical assistance for the purpose of
obtaining federal matching dollars: Provided, That if
such judgment or order specifies a later date on which
the prohibition takes effect, that later effective date
controls;

21 (3) The date upon which the Legislature appropriates
the proceeds from the tax levied under article twenty-
six, chapter eleven of this code, for any purpose not in
conformity with this article;

25 (4) The date upon which any federal administrative
rule or regulation promulgated in conformity with
federal law becomes effective which negates the effect
or purpose of this article: Provided, That if such federal
rule or regulation specifies a later date on which the
prohibition takes effect, that later effective date
controls: Provided, however, That if any rule or regula-
tion prohibits the inclusion of revenue from taxes
collected from a specific provider group defined in
section one of this article when determining the amount
of state expenditures that are claimable as medical
assistance for purposes of obtaining federal matching
dollars, such rule or regulation shall not affect, impair
or invalidate the application of this article to the
remaining health care providers, but shall be confined
in its operation to the provider group specifically
excluded by such rule or regulation; or

37 (5) The first day of July, one thousand nine hundred
ninety-four.

44 (b) Upon abrogation of this article, the single state
agency shall use the moneys remaining in the funds to
maintain, to the greatest extent possible, the increased
fee schedules as determined by the boards. Thereafter,
the single state agency shall distribute any moneys
insufficient to maintain the increased fee schedules
distributed on a proportional basis among all participat-
ing health care providers, from their respective funds,
as determined by the secretary.

53 (c) Upon abrogation, the medicaid reimbursement
levels shall return to those amounts in existence on the
thirty-first day of December, one thousand nine hundred
ninety-one.

CHAPTER 11. TAXATION.

ARTICLE 26. HEALTH CARE PROVIDER MEDICAID ENHANCEMENT TAX.

§11-26-1. Legislative findings.
1 The Legislature finds and declares that:
2 (a) Medicaid provides access to basic medical care for
3 our citizens who are not physically, mentally or
4 economically able to provide for their own care;
5 (b) Inadequate compensation for health care providers
6 rendering medicaid services is a barrier to indigent
7 persons seeking access to health care services;
8 (c) Health care providers in this state are providing
9 care, without compensation, to many citizens who are
10 not medicaid eligible;
11 (d) Many health care providers are leaving this state
12 due to economic conditions;
13 (e) Without adequate compensation this state cannot
14 attract or retain a sufficient number of health care
15 providers necessary to serve our indigent population;
16 (f) Without additional medicaid funding this state
17 cannot adequately compensate health care providers for
18 the health care services rendered to indigent patients;
19 (g) The Tenth Amendment of the United States
20 Constitution guarantees to the states the power to tax;
21 (h) The Congress of the United States has enacted
22 Section 4701 of the Omnibus Budget Reconciliation Act
23 of 1990, P.L. 101-508, amending Section 1902 of the
24 Social Security Act and authorizes state medicaid
25 agencies to attribute taxes imposed on medicaid
26 providers as part of the state share;
27 (i) By levying a tax on the medicaid reimbursements
28 of health care providers for the purpose of meeting state
29 fund matching requirements pursuant to Title XIX of
the Social Security Act, federal matching funds will be increased;

(j) By dedicating such additional revenue to the medicaid program, health care provider fees may conform as closely as possible to usual and customary charges;

(k) Moneys generated in accordance with this article are supplementary only and shall not be used to reduce the general financial obligations of the state's medical assistance program as appropriated by the Legislature;

(l) These funds shall not be used for any purpose other than those purposes stated in this article and articles four-b and four-c, chapter nine of this code; and

(m) The medicaid enhancement boards and medicaid enhancement funds created pursuant to articles four-b and four-c, chapter nine of this code are created to carry out the purposes of this article.

§ 11-26-2. Short title; arrangement and classification.

This article may be cited as the “West Virginia Health Care Provider Medicaid Enhancement Tax Act of 1991.” No inference, implication or presumption of legislative construction shall be drawn or made by reason of the location or grouping of any particular section or provision or portion of this article, and no legal effect shall be given to any descriptive matter or heading relating to any part, section, subdivision or paragraph of this article.

§ 11-26-3. Definitions.

The following words when used in this article have the meaning ascribed to them in this section, except in those instances where a different meaning is distinctly expressed or the context in which the word is used clearly indicates a different meaning is intended:

(a) “Cost-based service” means any service delivered by a health care provider reimbursed under the medical assistance program of this state solely on the basis of costs reported to the single state agency, whether or not the provider is operating on a profit or not for profit
basis.

(b) "Department" means the West Virginia department of health and human resources. The term "secretary" means the secretary of the West Virginia department of health and human resources, or his or her designee.

c) "Gross receipts" or "gross proceeds" means all payments received by a health care provider enrolled in this state's medical assistance program for services delivered pursuant to Title XIX of the United States Social Security Act, as amended, and means any and all medicaid reimbursement payments made by the West Virginia department of health and human resources, or a division thereof, within the limitations set forth in this subsection, to such health care provider: Provided, That this definition does not include payments received for medicare co-insurance and deductibles as defined in Title XVIII of the Social Security Act, and does not include reimbursements made for cost-based services.

d) "Health care provider" or "provider" includes physician providers as defined in section one, article four-b, chapter nine of this code; ambulance service providers, dentist providers, general health care providers, and outpatient hospital service providers as defined in section one, article four-c, chapter nine of this code, and any other person directly receiving enhanced medicaid reimbursement payments pursuant to article four-b or four-c, chapter nine of this code.

e) "Single state agency" means the single state agency for medicaid in this state.

(f) "Taxpayer" means a health care provider required to pay the medicaid enhancement tax imposed by this article and entitled to receive the increased reimbursement in accordance with articles four-b or four-c, chapter nine of this code.

§11-26-4. Imposition of excise tax; rate and application of tax.

(a) There is hereby levied and imposed an excise tax on the gross receipts or gross proceeds derived by health
care providers enrolled in this state's medical assistance program. The amount of the tax shall be equal to one hundred percent of that portion of gross receipts paid to the health care provider by the single state agency from state revenues for all services delivered pursuant to Title XIX of the United States Social Security Act, to individuals who, at the time such services were delivered, were enrolled with the single state agency and eligible to receive medicaid services, whether such health care provider is located within or without this state or such service is delivered within or without this state: Provided, That the following are not subject to the tax imposed in this article:

(1) Gross receipts or gross proceeds derived by a health care provider from delivering cost-based services;

(2) That portion of a health care provider's reimbursement when the secretary certifies the state share so that the medicaid reimbursement consists solely of federal financial participation, except that any gross receipts or gross proceeds derived by a health care provider from delivering medicaid services that are not reimbursed on a certified match basis, are taxable under this article: Provided, That nothing in this section prohibits the department from removing a service, or provider group, from the certified match program and placing that service, or provider group, under full medicaid payments subject to the tax imposed by this article; and

(3) Employees or agents of a health care provider when that employee or agent does not directly receive the medicaid reimbursement payment.

(b) The tax imposed by this section applies solely and exclusively to that portion of the medicaid reimbursement payment made from state revenue for services delivered by the health care provider pursuant to Title XIX of the United States Social Security Act, as amended, which amount shall be determined as provided in subdivision (c) of this section.

(c) From time to time, as is necessary, the secretary shall notify the tax commissioner in writing of the
portion, stated as a uniform percentage, of each
medicaid reimbursement payment taxable under this
article that constitutes the state's share of medicaid
program financial obligations in order to determine and
tax only the state revenue share of that medicaid
reimbursement payment. After receipt of such notice,
the tax commissioner shall immediately cause to be
published in the state register notice of that percentage
and its effective date for purposes of calculating the tax
imposed by this article. Beginning the first day of
January, one thousand nine hundred ninety-two, and
continuing until a notice of change in this percentage
takes effect, the state revenue share of a medicaid
reimbursement is twenty-two and thirty-two hundredths
percent, except as otherwise provided in this article.

§11-26-5. Administration.

(a) The tax commissioner shall collect the tax imposed
by this article. After consultation with the secretary, the
tax commissioner may establish procedures and pres-
cribe forms necessary to implement and enforce this
article. The tax commissioner shall account for all
collections of the tax imposed by this article and for all
collections of additions to tax, penalties and interest
imposed with respect to this tax under article ten of this
chapter. The amount collected shall be deposited, within
fifteen days after its receipt by the tax commissioner,
into the special revenue funds created in the state
treasury by articles four-b and four-c, chapter nine of
this code, as follows:

(1) **The physician provider medicaid enhancement fund.** — All taxes, additions to tax, penalties and interest collected in accordance with this article from those health care providers represented by the physician medicaid enhancement board and all donations and contributions received by the board in accordance with section five, article four-b, chapter nine of this code shall be deposited into the physician provider medicaid enhancement fund;

(2) **General medicaid enhancement fund.** — All taxes,
additions to tax, penalties and interest collected in
according to this article from those health care providers represented by the general Medicaid enhancement board and all donations and contributions received by the board in accordance with section seven, article four-c, chapter nine of this code shall be deposited into the general Medicaid enhancement fund;

(3) The outpatient hospital Medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected in accordance with this article from outpatient hospital providers represented by the outpatient hospital provider Medicaid enhancement board and all donations and contributions received by the board in accordance with section seven, article four-c, chapter nine of this code shall be deposited into the outpatient hospital Medicaid enhancement fund;

(4) The dentist provider Medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected in accordance with this article from dentist providers represented by the dentist provider Medicaid enhancement board and all donations and contributions received by the board in accordance with section seven, article four-c, chapter nine of this code shall be deposited into the dentist provider Medicaid enhancement fund; and

(5) The ambulance services provider Medicaid enhancement fund. — All taxes, additions to tax, penalties and interest collected in accordance with this article from ambulance service providers represented by the ambulance service provider Medicaid enhancement board and all donations and contributions received by the board in accordance with section seven, article four-c, chapter nine of this code shall be deposited into the ambulance services provider Medicaid enhancement fund.

(b) If a health care provider is represented by two or more boards, the tax paid by that provider shall be categorized and identified so that the tax commissioner may deposit the tax collected into the proper fund or funds.

(c) The department shall provide the tax commissioner with any information in its possession that the tax
commissioner considers necessary for proper enforcement of this article. Notwithstanding any provision in this code to the contrary, the tax commissioner may enter into a written exchange of information agreement with the secretary to disclose return information pertaining to the tax imposed by this article for the purpose of facilitating administration of this state's medical assistance program. Any confidential information disclosed under this agreement shall remain confidential in the hands of the receiving agency as provided in section five-d, article ten of this chapter.

(d) For fiscal year one thousand nine hundred ninety-two, not more than two hundred thousand dollars from the several medicaid enhancement funds shall be used for administrative purposes with respect to this article and articles four-b and four-c, chapter nine of this code; of this amount, not more than one hundred twenty-five thousand dollars shall be transferred to a special revenue account in the treasury for use by the department of tax and revenue and not more than seventy-five thousand dollars shall be transferred to a special revenue account in the treasury for use by the department of health and human resources.

(e) The secretary shall cause the remainder of all moneys deposited in the several medicaid enhancement funds, after administrative expenses, to be transferred to the West Virginia medical services fund.

(f) Notwithstanding the provisions of subsections (d) and (e) of this section, for fiscal year one thousand nine hundred ninety-three and for each succeeding fiscal year, no expenditures from any of the several medicaid enhancement funds are authorized except in accordance with appropriations by the Legislature.


(a) General rule. — For purposes of the tax imposed by this article, a taxpayer's taxable year shall be the same as the taxpayer's taxable year for federal income tax purposes.

(b) Change of taxable year. — If a taxpayer's taxable
year is changed for federal income tax purposes, the taxpayer's taxable year for purposes of this article shall be similarly changed. The taxpayer shall provide a copy of the authorization for such change from the Internal Revenue Service, with its annual return for the taxable year filed under this article.

(c) Cash methods of accounting required. — A taxpayer's method of accounting under this article shall be the cash method of accounting, whether or not taxpayer uses the cash method of accounting for federal income tax purposes.

§11-26-7. Tax return and payment.

(a) The annual tax levied by this article is due and payable in monthly installments, on or before the fifteenth day of the month succeeding the month in which the taxable gross receipts were received, except that the tax levied for the last month of the taxable year is due and payable on or before the last day of the first month of the next succeeding taxable year.

(b) The taxpayer shall, on or before the fifteenth day of each month, except for the last month of the taxable year, complete and mail to the tax commissioner a return for the preceding month, in the form prescribed by the tax commissioner, showing:

(1) The total gross receipts or gross proceeds received for services delivered pursuant to Title XIX of the Social Security Act, as amended, for that particular month;

(2) the gross proceeds upon which the tax is based;

(3) the amount of the tax for which the taxpayer is liable; and

(4) any other information necessary in the computation and collection of the tax which the tax commissioner may require. The taxpayer shall include with the return a remittance for the amount of the tax for the period covered by the return.

(c) On or before the last day of the first month after the end of the taxable year, every taxpayer subject to the tax imposed by this article shall make and file an
annual return for the entire taxable year showing such
information as the tax commissioner may require and
computing the amount of taxes due under this article
for the entire taxable year. The tax commissioner shall
allow a credit against this annual tax liability for the
amount of tax imposed by this article (exclusive of any
addition to tax, penalties or interest paid with respect
thereto) previously paid by the taxpayer on gross
receipts included in the annual return. The taxpayer
shall submit with the annual return a remittance for the
net amount of tax shown to be due.

§11-26-8. Extension of time for filing returns.

The tax commissioner may, upon written request
received on or prior to the due date of the annual return
or any periodic estimate, grant a reasonable extension
of time for filing any return or other document required
by this article, upon such terms as he or she may by rule
prescribe, or by contract require, if good cause satisfac-
tory to the tax commissioner is provided by the
taxpayer.


(a) Amount determined on return. — The tax commis-
ioner may extend the time for payment of the amount
of the tax shown, or required to be shown, on any return
required by this article (or any periodic installment
payments), for a reasonable period not to exceed six
months from the date fixed for payment thereof.

(b) Amount determined as deficiency. — Under rules
prescribed by the tax commissioner, he or she may
extend the time for the payment of the amount deter-
mined as a deficiency of the taxes imposed by this
article for a period not to exceed eighteen months from
the date fixed for payment of the deficiency. In
exceptional cases, a further period of time not to exceed
twelve months may be granted. The tax commissioner
may grant an extension under this subsection only
where it is shown to his or her satisfaction that payment
of a deficiency upon the date fixed for the payment
thereof will result in undue hardship to the taxpayer.
(c) No extension for certain deficiencies. — The tax commissioner may not grant an extension under this section for any deficiency if the deficiency is due to negligence, to intentional disregard of rules and regulations, or to fraud with intent to evade tax.

§11-26-10. Place for filing returns or other documents.

Tax returns, statements, or other documents, or copies thereof, required by this article or by rules shall be filed with the tax commissioner by delivery, in person or by mail, to his or her office in Charleston, West Virginia: Provided, That the tax commissioner may, by rule, prescribe the place for filing such returns, statements, or other documents, or copies thereof.


(a) General. — Any return, statement or other document required to be made under the provisions of this article shall be signed in accordance with instructions or regulations prescribed by the tax commissioner.

(b) Signing of corporation returns. — The president, vice president, treasurer, assistant treasurer, chief accounting officer or any other duly authorized officer shall sign the return of a corporation. In the case of a return made for a corporation by a fiduciary, the fiduciary shall sign the return. The fact that an individual's name is signed on the return is prima facie evidence that the individual is authorized to sign the return on behalf of the corporation.

(c) Signing of partnership returns. — Any one of the partners shall sign the return of a partnership. The fact that a partner's name is signed on the return is prima facie evidence that that partner is authorized to sign the return on behalf of the partnership.

(d) Signature presumed authentic. — The fact that an individual's name is signed to a return, statement, or other document is prima facie evidence for all purposes that the return, statement or other document was actually signed by him or her.

(e) Verification of returns. — Except as otherwise
provided by the tax commissioner, any return, declaration or other document required to be made under this article shall contain or be verified by a written declaration that it is made under the penalties of perjury.

§11-26-12. Records.

(a) Every health care provider liable for reporting or paying tax under this article shall keep such records, receipts, invoices, and other pertinent papers in such forms as the tax commissioner may require.

(b) Every taxpayer shall keep such records for not less than three years after the annual return is filed as required under this article, unless the tax commissioner in writing authorizes their earlier destruction. An extension of time for making an assessment shall automatically extend the time period for keeping the records for all years subject to audit covered in the agreement for extension of time.

§11-26-13. Refunds and credits.

(a) General rule. — In the case of erroneous payment of the tax imposed by this article, or the erroneous payment of additions to tax, penalties or interest imposed, pursuant to article ten of this chapter, with respect to the tax imposed by this article, the tax commissioner shall, subject to the provisions of this section, refund to the taxpayer the amount of the erroneous payment or, if the taxpayer so elects, apply the same as a credit against the taxpayer's liability for this tax for other periods. The amount refunded or credited shall include any interest due the taxpayer under the provisions of section seventeen, article ten of this chapter.

(b) Claim for refund or credit. — No refund or credit shall be made unless the taxpayer filed a timely claim for refund or credit with the tax commissioner setting forth the amount to be refunded along with the reason or reasons why the taxpayer believes the amount should be refunded, or credited to taxpayer's account, and a copy of any papers supporting the taxpayer's claim. A
person against whom an assessment, or an administrative decision, has become final with respect to this tax is not entitled to pay the amount thereof and then file a claim for refund or credit of the amount paid. The tax commissioner shall determine the validity of taxpayer's claim and notify the taxpayer in writing of his or her determination.

(c) Petition for refund or credit; hearing. — If the taxpayer is not satisfied with the tax commissioner's determination of his or her claim for refund or credit, or if the tax commissioner has not determined the taxpayer's claim within ninety days after the claim was filed, the taxpayer may file with the tax commissioner, either by personal service or by certified mail, a petition for refund or credit: Provided, That no petition for refund or credit may be filed more than sixty days after the taxpayer is served with a notice of the denial of his or her claim. The petition for refund or credit shall be in writing, verified under oath by the taxpayer or his or her duly authorized agent having knowledge of the facts, and shall set forth with particularity the items of the determination objected to, together with the reasons for the objections. When a petition for refund or credit is properly filed, the procedures for hearing and for decision prescribed in section nine, article ten of this chapter shall be followed.

(d) Appeal. — An appeal from the tax commissioner's decision upon the petition for refund or credit may be taken by the taxpayer in the same manner and under the same procedure as that set forth in section eleven of article ten of this chapter relating to an appeal from the tax commissioner's decision on a petition for assessment, but no bond shall be required of the taxpayer.

(e) Decision of the court. — Whenever an appeal is to review an administrative decision on a petition for refund or credit, the court may determine the legal rights of the parties but in no event shall it enter a judgment for money.

(f) Refund made or credit established. — The tax
commissioner shall promptly issue his or her requisition
on the treasury or establish a credit, as requested by the
taxpayer, for any amount finally administratively or
judicially determined to be an erroneous payment of any
tax administered under this article. The auditor shall
issue his or her warrant on the treasurer for any refund
requisitioned under this subsection payable to the
taxpayer entitled to the refund, and the treasurer shall
pay such warrant out of the fund into which the amount
so refunded was originally paid.

(g) Forms for claim for refund or credit. — The tax
commissioner may prescribe by rule or regulation the
forms for claims for refund or credit.

(h) Remedy exclusive. — The procedure provided by
this section constitutes the sole method of obtaining any
refund or any credit, it being the intent of this section
that the procedure set forth in this article is in lieu of
the procedure set forth in section fourteen, article ten
of this chapter, and in lieu of any other remedy,
including the uniform declaratory judgments act
embodied in article thirteen, chapter fifty-five of this
code and the provisions of section two-a, article one of
this chapter.

(i) Erroneous refund made or credit established. — If
the tax commissioner believes that an erroneous refund
has been made or an erroneous credit has been estab-
lished, he or she may proceed to investigate and may
make an assessment to recover the amount of such
refund or credit within two years after the date the
refund was paid or the credit was established, unless a
fraudulent claim was filed. In that event, the two
statutes of limitations shall be six years.

(j) Limitation on claim for refund or credit. —

(1) General rule. — Whenever a taxpayer claims to be
entitled to a refund or credit for erroneous payment of
any tax, additions to tax, penalties or interest paid into
the treasury of this state, the taxpayer shall, except as
provided in subsection (d) of this section, file his or her
claim within three years after the due date of the return
in respect of which the tax was imposed or within two
years from the date the tax was paid, whichever of such periods expires later, or if no return was filed by the taxpayer, within two years from the time the tax was paid, and not thereafter.

(2) Extension of time for filing claim by agreement. — The tax commissioner and the taxpayer may enter into written agreement to extend the period within which the taxpayer may file a claim for refund or credit, which period shall not exceed two years. The period agreed upon may be extended for additional periods not in excess of two years each by subsequent agreements in writing made before the expiration of the period previously agreed upon.

(3) Special rule where agreement to extend time for making an assessment. — Notwithstanding subdivisions (1) and (2) of this subsection, if an agreement is made under the provisions of section fifteen of this article extending the time period in which an assessment of a tax can be made, then the time period for filing a claim for refund or credit for an erroneous payment of the same tax made during the periods subject to assessment under the erroneous payment of this tax made during the periods subject to assessment under the extension agreement shall also be extended for the period of the extension agreement plus ninety days.

(k) “Erroneous payment” defined. — The term erroneous payment means a payment of the tax imposed by this article or the additions to tax, penalties or interest imposed with respect to this tax pursuant to article ten of this chapter, when such payment is due to a mathematical or clerical error or when such payment is collected after the period of limitation properly applicable thereto.

§11-26-14. Cancellation of medicaid certification for failure to pay delinquent tax.

The secretary may cancel or refuse to issue, extend, or reinstate a medicaid enrollment to any provider who has failed to pay any tax that is delinquent under this article.
§11-26-15. General procedure and administration.

Each and every provision of the "West Virginia Tax Procedure and Administration Act" set forth in article ten of this chapter applies, except as expressly provided in this article, to the tax imposed by this article with like effect as if the act were applicable only to the tax imposed by this article and were set forth in extenso in this article.


Each and every provision of the "West Virginia Tax Crimes and Penalties Act" set forth in article nine of this chapter applies to the tax imposed by this article with like effect as if the act were applicable only to the tax imposed by this article and were set forth in extenso in this article.

§11-26-17. Effective dates.

(a) The tax imposed by this article takes effect on the first day of January, one thousand nine hundred ninety-two, and applies to gross receipts received on or after that date: Provided, That the tax with respect to providers whose fee schedules require prior approval of the health care financing administration is effective on the effective date approved by the health care financing administration: Provided, however, That the tax with respect to those providers whose fees are 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, article four-c, chapter nine of this code.

(b) Any change in the percentage of medicaid reimbursement that constitutes state revenue for purposes of calculating this tax, published as provided in subsection (c), section three of this article, applies first to gross receipts received during any calendar month that begins not less than thirty days after notice of a change in the percentage is filed in the state register, or the first day of any later calendar month specified in the notice. The percentage remains in effect until a subsequent change in the percentage takes effect and applies to taxable
gross receipts received during the period during which the percentage was in effect, whether or not the medicaid services were furnished, supplied, or rendered during that period.


(a) This tax abrogates and is of no further force and effect, without any further action by the Legislature, upon the earliest of the following dates:

1. The date upon which an act of Congress becomes effective prohibiting the inclusion of revenue from provider taxes when determining the amount of state expenditures that are claimable as medical assistance for purposes of obtaining federal matching dollars: Provided, That if such act specifies a later date on which such prohibition takes effect, that later effective date controls;

2. The date upon which a judgment or order of a court of competent jurisdiction becomes final prohibiting the inclusion of revenue from provider taxes when determining the amount of state expenditures that are claimable as medical assistance for purposes of obtaining federal matching dollars: Provided, That if such judgment or order specifies a later date on which the prohibition takes effect, that later effective date controls;

3. The date upon which the Legislature appropriates the proceeds from this tax for any purpose not in conformity with this article;

4. The date upon which any federal administrative rule or regulation promulgated in conformity with federal law becomes effective which negates the effect or purpose of this article: Provided, That if such federal rule or regulation specifies a later date on which the prohibition takes effect, that later effective date controls: Provided, however, That if any rule or regulation prohibits the inclusion of revenue from taxes collected from a specific provider group defined in section three of this article, when determining the amount of state expenditures that are claimable as
medical assistance for purposes of obtaining federal
matching dollars, such rule or regulation shall not
affect, impair or invalidate the application of this article
to the remaining health care providers, but shall be
confined in its operation to the provider group specific-
ally excluded by such rule or regulation; or

(5) The first day of July, one thousand nine hundred
ninety-four.

(b) If this article is abrogated as provided in subsec-
tion (a), abrogation applies only with respect to gross
receipts received by the health care provider on or after
the effective date of the abrogation. With respect to
gross receipts received by the health care provider prior
to such date, the tax imposed by this article remains in
effect and all rights of this state and of the taxpayer
with respect to such tax are fully and completely
preserved as if this tax had not abrogated.

(c) Upon abrogation of this article, moneys remaining
in the funds shall be used to maintain, to the greatest
extent possible, the increased fee schedules as adopted
by the single state agency through recommendations by
the boards. Thereafter, any moneys insufficient to
maintain the increased fee schedules shall be distributed
on a proportional basis among all participating provid-
ers, from their respective funds, as determined by the
secretary.

(d) Upon abrogation, medicaid reimbursement levels
shall return to the amounts in existence on the thirty-
first day of December, one thousand nine hundred
ninety-one.


If any provision of this article or the application
thereof shall for any reason be adjudged by any court
of competent jurisdiction to be invalid, such judgment
shall not affect, impair or invalidate the remainder of
said article, but shall be confined in its operation to the
provision thereof directly involved in the controversy in
which such judgment shall have been rendered, and the
applicability of such provision to other persons or
circumstances shall not be affected thereby.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.

Takes effect from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the ___ day of November, 1991.

Governor