

1 ENROLLED

2 COMMITTEE SUBSTITUTE

3 FOR

4 H. B. 4217

5
6 (By Delegates Perdue, Fleischauer, Campbell,
7 Ellington, Morgan and Stephens)

8 [Passed March 8, 2014; in effect ninety days from passage.]
9

10 AN ACT to amend the Code of West Virginia, 1931, as amended, by
11 adding thereto two new sections, designated §9-5-22 and
12 §9-5-23, all relating to Medicaid; requiring the Bureau of
13 Medical Services to submit an annual report to the
14 Legislature; requiring certain information to be included in
15 the report; requiring website publication of certain
16 information.

17 *Be it enacted by the Legislature of West Virginia:*

18 That the Code of West Virginia, 1931, as amended, be amended
19 by adding thereto two new sections, designated §9-5-22 and §9-5-23,
20 all to read as follows:

21 **ARTICLE 5. MISCELLANEOUS PROVISIONS.**

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

23 (a) Beginning January 1, 2016, and annually thereafter, the
24 Bureau for Medical Services shall submit an annual report by May of
25 that year to the Joint Committee on Government and Finance and the
26 Legislative Oversight Commission on Health and Human Resources

1 Accountability that includes, but is not limited to, the following
2 information for all managed care organizations:

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

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

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

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

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

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

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

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

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

26 (10) A copy of the member and provider satisfaction survey

1 report for each managed care organization.

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

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

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

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

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

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

17 (A) Total number of prescription claims;

18 (B) Total number of prescription claims denied;

19 (C) Average adjudication time for prescription claims;

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

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

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

26 (G) Total number of prescription claims adjudicated after

1 ninety days.

2 (17) The total number of authorizations by service.

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

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

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

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

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

25 (1) Aggregate dollars expended by both managed care
26 organizations and fee-for-service providers of the Medicaid

1 programs per fiscal years; and

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

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

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

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

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