1 **COMMITTEE SUBSTITUTE**

2 **FOR**

3 **H. B. 4217**

4

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

7 (Originating in the Committee of Health and Human Resources

8 (January 22, 2014)

9

10

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

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

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

22 **ARTICLE 5. MISCELLANEOUS PROVISIONS.**

23 **§9-5-22. Medicaid managed care reporting.**

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

1 Human Resources Accountability that includes, but is not limited
2 to, the following information:
3 (1) The name and geographic service area of each managed care
4 network that has contracted with the bureau.
5 (2) The total number of health care providers in each managed
6 care network broken down by provider type and specialty and by each
7 geographic service area.
8 (3) The monthly average and total of the number of members
9 enrolled in each network broken down by eligibility group.
10 (4) The percentage of primary care practices that provide
11 verified continuous phone access with the ability to speak with a
12 primary care provider clinician within thirty minutes of member
13 contact for each managed care network.
14 (5) The percentage of regular and expedited service
15 authorization requests processed within the time frames specified
16 by the contract for each managed care network.
17 (6) The percentage of claims paid each provider type within
18 thirty calendar days and the average number of days to pay all
19 claims for each managed care network.
20 (7) The number of claims denied, pended or reduced by each
21 managed care network for each of the following reasons:
22 (A) Lack of documentation to support medical necessity;
23 (B) Prior authorization was not on file;
24 (C) Member has other insurance that must be billed first;
25 (D) Claim was submitted after the filing deadline; and
26 (E) Service was not covered by the managed care network due to

1 process, procedure, notification, referrals, or any other required
2 administrative function of a managed care network.
3 (8) The number and dollar value of all claims paid to non-
4 network providers by claim type categorized by emergency services
5 and non-emergency services for each managed care network by
6 geographic service area.
7 (9) The number of members choosing the managed care network
8 and the number of members auto-enrolled into each managed care
9 network, broken down by managed care network.
10 (10) The amount of the average per member per month payment
11 and total payments paid to each managed care network.
12 (11) The medical loss ratio and the administrative cost of
13 each managed care company and the amount of money refunded to the
14 state if the contract contains a medical loss ratio.
15 (12) A comparison of health outcomes, which includes, but is
16 not limited to, the following outcomes:
17 (A) Adult asthma admission rate;
18 (B) Congestive heart failure admission rate;
19 (C) Uncontrolled diabetes admission rate;
20 (D) Adult access to preventative/ambulatory health services;
21 (E) Breast cancer screening rate;
22 (F) Well child visits; and
23 (G) Childhood immunization rates.
24 (13) A copy of the member and provider satisfaction survey
25 report for each managed care network.
26 (14) A copy of the annual audited financial statements for

1 each managed care network.

2 (15) The total amount of savings to the state for each shared

3 savings managed care network.

4 (16) A brief factual narrative of any sanctions levied by the

5 department against a managed care network.

6 (17) The number of members, broken down by each managed care

7 network, 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 (18) The number of members receiving unduplicated Medicaid

11 services from each managed care network, broken down by provider

12 type, specialty, and place of service.

13 (19) The number of members receiving unduplicated outpatient

14 emergency services, broken down by managed care network and

15 aggregated by the following hospital classifications:

16 (A) State;

17 (B) Public non-state non-rural;

18 (C) Rural; and

19 (D) Private.

20 (20) The number of total inpatient Medicaid days broken down

21 by managed care network and aggregated by the following hospital

22 classifications:

23 (A) State;

24 (B) Public non-state non-rural;

25 (C) Rural; and

26 (D) Private.

1 (21) The number of claims for emergency services, broken out
2 by managed care network, whether the claim was paid or denied by
3 provider type.
4 (22) The following information concerning pharmacy benefits
5 broken down by each managed care network and by month:
6 (A) Total number of prescription claims;
7 (B) Total number of prescription claims subject to prior
8 authorization;
9 (C) Total number of prescription claims denied;
10 (D) Total number of prescription claims subject to
11 step-therapy or failed first protocols; and
12 (E) Total number of prescription drugs by therapeutic
13 classification.
14 (23) The total number of authorizations by service each month.
15 (24) Any other metric or measure which the Bureau of Medical
16 Services deems appropriate for inclusion in the report.
17 **§9-5-23. Bureau of Medical Services information.**
18 (a) The Bureau of Medical Services shall publish all
19 informational bulletins, health plan advisories, and guidance
20 published by the department concerning the Medicaid program on the
21 department's website.
22 (b) The bureau shall publish all Medicaid state plan
23 amendments and any related correspondence within twenty-four hours
24 of receipt of the correspondence submission to the Centers for
25 Medicare and Medicaid Services.
26 (c) The bureau shall publish all formal responses by the

1 Centers for Medicare and Medicaid Services regarding any state plan

2 amendment on the department's website within twenty-four hours of

receipt of the correspondence.

NOTE: The purpose of this bill is require an annual report containing information about Medicaid managed care be provided to the Legislative Oversight Commission on Health and Human Resources.

Both sections are new; therefore, they have been completely underscored.