WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

Senate Bill 490

BY SENATORS TAKUBO AND STOLLINGS

[Introduced February 3, 2016;

Referred to the Committee on Health and Human

Resources.]

1 A BILL to amend the Code of West Virginia, 1931, as amended, by adding thereto a new article,
2 designated §33-25H-1, §33-25H-2 and §33-25H-3, all relating to requiring managed care
3 programs to participate with any willing heath provider who provides delivery of services
4 to persons receiving Medicaid; providing exclusions; allowing for a plan or correction; and
5 defining terms.

Be it enacted by the Legislature of West Virginia:

1 That the Code of West Virginia, 1931, as amended, be amended by adding thereto a new
2 article designated §33-25H-1, §33-25H-2 and §33-25H-3, all to read as follows:

ARTICLE 25H. MANAGED CARE TRANSPARENCY.

§33-25H-1. Definitions.

1 As used in this article:
2 (1) "Health care provider" means any physician licensed pursuant to the provision of
3 articles three and fourteen, chapter thirty of this code or an entity subject to licensure pursuant to
4 the provisions of article five-b, chapter sixteen of this code.
5 (2) "Health maintenance organization" or "managed care organization or plan" means a
6 public or private organization which provides, or otherwise makes available to enrollees, health
7 care services, including at a minimum basic health care services and which:
8 (A) Receives premiums for the provision of basic health care services to enrollees on a
9 prepaid per capita or prepaid aggregate fixed sum basis, excluding copayments;
10 (B) Provides physicians' services primarily:
11 (i) Directly through physicians who are either employees or partners of the organization;
12 (ii) Through arrangements with individual physicians or one or more groups of physicians
13 organized on a group practice or individual practice arrangement; or
14 (iii) Through some combination of paragraphs (i) and (ii) of this subdivision;
15 (C) Assures the availability, accessibility and quality, including effective utilization, of the
16 health care services which it provides or makes available through clearly identifiable focal points

17 of legal and administrative responsibility; and

18 (D) Offers services through an organized delivery system in which a primary care
19 physician or primary care provider is designated for each subscriber upon enrollment. The primary
20 care physician or primary care provider is responsible for coordinating the health care of the
21 subscriber and is responsible for referring the subscriber to other providers when necessary.

22 (3) "Medicaid" means a joint federal-state program that provides health care insurance to
23 low-income persons codified at 42 U.S.C.A. § 1396.

§33-25H-2. Prohibition against discrimination.

1 Any health maintenance organization or managed care organization or plan is prohibited
2 from discriminating against any willing health care provider who provides services to the Medicaid
3 population, as defined in this section, if the health care provider is willing to meet the terms and
4 conditions for participation established by a health maintenance organization or managed care
5 organization or plan. Any provider shall meet licensing requirements set by law, shall have a
6 Medicaid provider number, and may not otherwise be disqualified from participating in Medicare
7 or Medicaid.

§33-25H-3. Exceptions; rulemaking.

1 (a) Should a health maintenance organization or a managed care organization or plan
2 wish to exclude a qualified health care provider from participation, the health maintenance
3 organization or a managed care organization or plan shall place the health care provider on notice.
4 This notice shall include, at a minimum, a list of quality indicators necessary for plan participation
5 and contain a detailed analysis of any deficiencies in the operation or facilities of the health care
6 provider which resulted in the exclusion. The health care provider and the health maintenance
7 organization or a managed care organization or plan shall enter into a plan of correction to allow
8 the health care provider an opportunity to correct the deficiencies.

9 (b) The Insurance Commissioner shall propose rules for legislative approval in accordance
10 with the provisions of article three, chapter twenty-nine-a of this code to accomplish the

11 requirements of this article and to establish a procedure for the notice requirements in subsection

12 (a) including timeframes for notice, the plan of correction and successful completion of the plan.

NOTE: The purpose of this bill is to require managed care programs to participate with any willing heath provider who provides delivery of services to persons receiving Medicaid.

Strike-throughs indicate language that would be stricken from a heading or the present law and underscoring indicates new language that would be added.