WEST VIRGINIA LEGISLATURE

2016 REGULAR SESSION

Introduced

House Bill 2920

2015 Carryover

(BY DELEGATES WALTERS, HOWELL, ARVON, KESSINGER AND HILL)

[Introduced January 13, 2016; referred to the Committee on Banking and Insurance then Finance.]

A BILL to amend and reenact §5-16-13 of the Code of West Virginia, 1931, as amended; to amend and reenact §9-2-6 of said code; and to amend and reenact §9-5-22 of said code, all relating to vesting the Public Employees Insurance Agency with the authority to negotiate and executing all health care and ancillary contracts for the Medicaid program.

Be it enacted by the Legislature of West Virginia:

That §5-16-13 of the Code of West Virginia, 1931, as amended, be amended and reenacted; that §9-2-6 of said code be amended and reenacted; and that §9-5-22 be amended and reenacted, all to read as follows:

CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL; BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES, COMMISSIONS, OFFICES, PROGRAMS, ETC.

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT.

§5-16-3. Composition of Public Employees Insurance Agency; appointment, qualification, compensation and duties of director of agency; employees; civil service coverage.

(a) The Public Employees Insurance Agency consists of the director, the Finance Board, the Advisory Board and any employees who may be authorized by law. The director shall be appointed by the Governor, with the advice and consent of the Senate, and serves at the will and pleasure of the Governor. The director shall have at least three years' experience in health or governmental health benefit administration as his or her primary employment duty prior to appointment as director. The director shall receive actual expenses incurred in the performance of official business. The director shall employ any administrative, technical and clerical

employees required for the proper administration of the programs provided in this article. The director shall perform the duties that are required of him or her under the provisions of this article and is the Chief Administrative Officer of the Public Employees Insurance Agency. The director may employ a deputy director.

(b) Except for the director, his or her personal secretary, the deputy director and the chief financial officer, all positions in the agency shall be included in the classified service of the civil service system pursuant to article six, chapter twenty-nine of this code.

(c) The director is responsible for the administration and management of the Public Employees Insurance Agency as provided in this article and in connection with his or her responsibility may make all rules necessary to effectuate the provisions of this article. Nothing in section four or five of this article limits the director's ability to manage on a day-to-day basis the group insurance plans required or authorized by this article, including, but not limited to, administrative contracting, studies, analyses and audits, eligibility determinations, utilization management provisions and incentives, provider negotiations, provider contracting and payment, designation of covered and noncovered services, offering of additional coverage options or cost containment incentives, pursuit of coordination of benefits and subrogation or any other actions which would serve to implement the plan or plans designed by the Finance Board. The director is to function as a benefits management professional and should avoid political involvement in managing the affairs of the Public Employees Insurance Agency.

(d) The director is a designee of the Department of Health and Human Resources to negotiate and execute contracts 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.

~~(d)~~ (e) The director may, if it is financially advantageous to the state, operate the Medicare

retiree health benefit plan offered by the agency based on a plan year that runs concurrent with the calendar year. Financial plans as addressed in section five of this article shall continue to be on a fiscal-year basis.

~~(e)~~ (f) The director should make every effort to evaluate and administer programs to improve quality, improve health status of members, develop innovative payment methodologies, manage health care delivery costs, evaluate effective benefit designs, evaluate cost sharing and benefit-based programs and adopt effective industry programs that can manage the long-term effectiveness and costs for the programs at the Public Employees Insurance Agency to include, but not be limited to:

(1) Increasing generic fill rates;

(2) Managing specialty pharmacy costs;

(3) Implementing and evaluating medical home models and health care delivery;

(4) Coordinating with providers, private insurance carriers and to the extent possible Medicare to encourage the establishment of cost-effective accountable care organizations;

(5) Exploring and developing advanced payment methodologies for care delivery such as case rates, capitation and other potential risk-sharing models and partial risk-sharing models for accountable care organizations and/or medical homes;

(6) Adopting measures identified by the Centers for Medicare and Medicaid Services to reduce cost and enhance quality;

(7) Evaluating the expenditures to reduce excessive use of emergency room visits, imaging services and other drivers of the agency's medical rate of inflation;

(8) Recommending cutting-edge benefit designs to the Finance Board to drive behavior and control costs for the plans;

(9) Implementing programs to encourage the use of the most efficient and high-quality

providers by employees and retired employees;

(10) Identifying employees and retired employees who have multiple chronic illnesses and initiating programs to coordinate the care of these patients;

(11) Initiating steps by the agency to adjust payment by the agency for the treatment of hospital acquired infections and related events consistent with the payment policies, operational guidelines and implementation timetable established by the Centers of Medicare and Medicaid Services. The agency shall protect employees and retired employees from any adjustment in payment for hospital acquired infections; and

(12) Initiating steps by the agency to reduce the number of employees and retired employees who experience avoidable readmissions to a hospital for the same diagnosis related group illness within thirty days of being discharged by a hospital in this state or another state consistent with the payment policies, operational guidelines and implementation timetable established by the Centers of Medicare and Medicaid Services.

~~(f)~~ (g) The director shall issue an annual progress report to the Joint Committee on Government and Finance on the implementation of any reforms initiated pursuant to this section and other initiatives developed by the agency.

CHAPTER 9. PUBLIC HEALTH.

ARTICLE 2. COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES AND RESPONSIBILITIES GENERALLY.

§9-2-6. Powers of secretary.

Within limits of state appropriations and federal grants and subject to provisions of state and federal laws and regulations, the secretary, in addition to all other powers, duties and responsibilities granted and assigned to that office in this chapter and elsewhere by law, is

authorized to:

(1) Promulgate, amend, revise and rescind department rules respecting the organization and government of the department and the execution and administration of those powers, duties and responsibilities granted and assigned by this chapter and elsewhere by law to the department and the secretary.

(2) Promulgate, amend, revise and rescind department rules and regulations respecting qualifications for receiving the different classes of welfare 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 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 of said article.

(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 those powers, duties and responsibilities granted and assigned by this chapter and elsewhere by law to the department and the secretary.

(4) Sign and execute in the name of the state by the State Department of Health and Human Resources any contract or agreement with the federal government or its agencies, other states, political subdivisions of this state, corporations, associations, partnerships or individuals: *Provided,* That the provisions of article three, chapter five-a are followed.

(5) Vest the Public Employees Insurance Agency with the authority to negotiate ~~Sign and execute a contract~~ contracts 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 Secretary will work in conjunction with PEIA during those negotiations and will sign and execute such contracts. ~~*Provided,* That the provisions of article three, chapter five-a are followed:~~ *Provided, however,* That a contract awarded under the agency purchasing process from April 1, 2009, to January 2, 2013, remains in full force and effect and the secretary retains sole authority to review, approve and issue changes to contracts issued under the former purchasing process, and is responsible for challenges, disputes, protests and legal actions related to such contracts.

(6) Establish such special funds as may be required by the federal Social Security Act, as amended, or by any other Act or Acts of Congress, in order for this state to take full advantage of the benefits and provisions thereof relating to the federal-state assistance and federal assistance programs administered by the department and to make payments into and disbursements out of any such special fund or funds in accordance with the requirements of the federal Social Security Act, as amended, or any other Act or Acts of Congress, and in accordance with applicable state law and the objects and purposes of this chapter. In addition, the State Department of Health and Human Resources, through the secretary, is hereby authorized to accept any and all 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 shall revert to the General Revenue Funds of this state. No expenses incurred pursuant to this special fund shall 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 and for the purpose of 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, quality control 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 article six, chapter twenty-nine of this code and rules promulgated thereunder. The Inspector General shall supervise all personnel of the Office of Inspector General.

(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 shall be paid more frequently than once in twelve 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 such reimbursement is limited

to a maximum amount of $250 per claim.

(11) Establish and maintain such institutions as are necessary for the temporary care, maintenance and training of children and other persons.

(12) 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.

(13) 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, such Board of Review to have such powers of a 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.

(14) 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.

(15) Provide by rules, consistent with requirements of applicable federal laws and rules, application forms and application procedures for the various classes of public assistance.

(16) Provide locations for making applications for the various classes of public assistance.

(17) Provide a citizen or group of citizens an opportunity to file objections and to be heard upon objections to the grant of any class of public assistance.

(18) Delegate to the personnel of the department all powers and duties vested in the secretary, except the power and authority to sign contracts and agreements.

(19) Make such reports in such form and containing such information as may be required by applicable federal laws and rules respecting federal-state assistance and federal assistance.

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

ARTICLE 5. MISCELLANEOUS PROVISIONS.

§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, the Procurement Division of the Public Employees Insurance Agency, 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 nonnetwork 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.

NOTE: The purpose of this bill to vest PEIA with the authority to negotiate and execute all contracts for health care and ancillary services for the Medicaid program.

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