

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Introduced

Senate Bill 791

By Senator Tarr

[Introduced February 14, 2024; referred
to the Committee on Finance]

1 A BILL to amend and reenact §9-4-3 of the Code of West Virginia, 1931, as amended, relating to
 2 modifying the membership requirements of the Medical Services Fund Advisory Council;
 3 augmenting its purpose; requiring that it employ an actuary; requiring certain actions from
 4 the Commissioner for the Bureau for Medical Services; and addressing the six-year plan to
 5 mitigate long-term financial liabilities.

Be it enacted by the Legislature of West Virginia:

ARTICLE 4. STATE ADVISORY BOARD; MEDICAL SERVICES FUND; ADVISORY

COUNCIL; GENERAL RELIEF FUND.

§9-4-3. Advisory council.

1 (a) (1) The advisory council, created by chapter 143, Acts of the Legislature, regular
 2 session, 1953, as an advisory body to the state Medicaid Agency with respect to the medical
 3 services fund and disbursements therefrom and to advise about health and medical services, is
 4 continued so long as the medical services fund remains in existence, and thereafter so long as the
 5 state Medicaid Agency considers the advisory council to be necessary or desirable, and it is
 6 organized as provided by this section and applicable federal law and has those advisory powers
 7 and duties as are granted and imposed by this section and elsewhere by law.

8 (2) The purpose of the Council is to bring fiscal stability to the Medicaid program through
 9 development of annual financial plans and long-range plans designed to meet the agency's
 10 estimated total financial requirements.

11 (b) The advisory council shall consist of not less than nine members, nor more than 15
 12 members, all but four of whom shall be appointed by the state Medicaid Agency and serve until
 13 replaced or reappointed on a rotating basis. These members shall include:

14 (1) The Secretary for the Department of Human Services, who shall serve as Chair of the
 15 Council;

16 (2) Chairs of the House and Senate Finance Committees, or their designees are members

17 ex officio;

18 (3) The President of the Senate and Speaker of the House of Delegates, or their
19 designees, are members ex officio;

20 (4) Four members shall be selected from the public at large, meeting the following
21 requirements:

22 (A) One member selected from the public at large shall generally have knowledge and
23 expertise relating to the financing, development, or management of employee benefit programs;

24 (B) One member selected from the public at large shall have at least three years of
25 experience in the insurance benefits business;

26 (C) One member selected from the public at large shall be a certified public accountant
27 with at least three years of experience with financial management and employee benefits program
28 experience; and

29 (D) One member selected from the public at large shall be a health care actuary or certified
30 public accountant with at least three years of financial experience with the health care
31 marketplace.

32 ~~(e)(1)~~ (5) The heads of the Bureau of Public Health and Bureau for Medical Services are
33 members ex officio.

34 ~~(2)~~ (6) The cochairs of the Legislative Oversight Commission on Health and Human
35 Resources Accountability, or their designees, are nonvoting ex officio members.

36 ~~(3)~~ (7) The remaining members comprising the council consist of:

37 (A) One member of recognized ability in the field of medicine and surgery with respect to
38 whose appointment the state Medical Association shall be afforded the opportunity of making
39 nomination of three qualified persons;

40 (B) One member of recognized ability in the field of dentistry with respect to whose
41 appointment the state Dental Association shall be afforded the opportunity of nominating three
42 qualified persons;

43 (C) One member chosen from a list of three persons nominated by the West Virginia
44 Primary Care Association;

45 (D) One member chosen from a list of three persons nominated by the Behavioral Health
46 Providers Association of West Virginia; and

47 (E) The remaining members chosen from persons of recognized ability in the fields of
48 hospital administration, nursing and allied professions and from consumers groups, including
49 Medicaid recipients, members of the West Virginia Directors of Senior and Community Services,
50 labor unions, cooperatives and consumer- sponsored prepaid group practices plans.

51 (F) No member of the council may be a registered lobbyist.

52 (G) All appointments shall be residents of West Virginia. All members of the Council shall
53 have a fiduciary responsibility to protect West Virginia's taxpayer interests and the interests of
54 Medicaid beneficiaries. Beginning July 1, 2025, and every year thereafter, all Council members
55 shall complete fiduciary training and timely complete any conflict-of-interest forms required to
56 serve as a fiduciary.

57 ~~(d)~~ (c) The council shall meet on call of the state Medicaid Agency.

58 ~~(e)~~ (d) Each member of the advisory council shall receive reimbursement for reasonable
59 and necessary travel expenses for each day actually served in attendance at meetings of the
60 council in accordance with the state's travel regulations. Requisitions for the expenses shall be
61 accompanied by an itemized statement, which shall be filed with the Auditor and preserved as a
62 public record.

63 (e) The advisory council shall assist the state Medicaid Agency in the establishment of
64 rules, standards and bylaws necessary to carry out the provisions of this section and shall serve as
65 consultants to the state Medicaid Agency in carrying out the provisions of this section.

66 (f) The council shall retain the services of an impartial, professional actuary, with
67 demonstrated experience in analysis of large group health insurance plans, to estimate the total
68 financial requirements of the Bureau for each fiscal year and to review and render written

69 professional opinions as to financial plans proposed by the Council. The actuary shall also assist
70 in the development of alternative financing options and perform any other services requested by
71 the Council, the Secretary, or the Commissioner. All reasonable fees and expenses for actuarial
72 services shall be paid by the Bureau for Medical Services.

73 (g) The Commissioner for the Bureau for Medical Services shall make every effort to
74 evaluate and administer programs to improve quality, improve health status of members, develop
75 innovative payment methodologies, manage health care delivery costs, evaluate effective benefit
76 designs, evaluate cost sharing and benefit-based programs, and adopt effective industry
77 programs that can manage the long-term effectiveness and costs for the Medicaid program, but
78 not be limited to:

79 (1) Increasing generic fill rates;

80 (2) Managing specialty pharmacy costs;

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

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

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

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

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

91 (8) Recommending cutting-edge benefit designs to the council to drive behavior and
92 control costs for the plans;

93 (9) Implementing programs to encourage the use of the most efficient and high-quality
94 providers by beneficiaries;

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

97 (11) Initiating steps to adjust payment by the agency for the treatment of hospital-acquired
98 infections and related events consistent with the payment policies, operational guidelines, and
99 implementation timetable established by the Centers of Medicare and Medicaid Services.

100 (12) Initiating steps to reduce the number of beneficiaries who experience avoidable
101 readmissions to a hospital for the same diagnosis-related group illness within 30 days of being
102 discharged by a hospital in this state or another state consistent with the payment policies,
103 operational guidelines, and implementation timetable established by the Centers of Medicare and
104 Medicaid Services.

105 (13) Identifying expenditure reduction opportunities to curtail benefits and eligible
106 populations in line with parameters approved by the Centers for Medicare and Medicaid Services
107 in other jurisdictions.

108 (14) Analyzing the Medicaid Six-Year Plan concerning assumptions that formulate
109 expenditure projections with the purpose of crafting strategies to mitigate long term financial
110 liabilities in the program.

NOTE: The purpose of this bill is to modify the Medical Services Fund Advisory Council membership requirements, augment its purpose, require that it employ an actuary, require certain actions from the Commissioner for the Bureau for Medical Services, and address the six-year plan to mitigate long-term financial liabilities.

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