

# **WEST VIRGINIA LEGISLATURE**

**2024 REGULAR SESSION**

**Committee Substitute**

**for**

**Senate Bill 791**

BY SENATOR TARR

[Originating in the Committee on Finance; reported

February 23, 2024]



1 A BILL to amend and reenact §9-4-3 of the Code of West Virginia, 1931, as amended; and to  
2 amend said code by adding thereto a new section, designated §9-5-34, all relating to  
3 Medicaid; modifying the membership requirements of the Medical Services Fund Advisory  
4 Council; augmenting its purpose; requiring that it employ an actuary; requiring certain  
5 actions from the Commissioner for the Bureau for Medical Services; and addressing the  
6 six-year plan to 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  
5 the 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~~25  
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 of Delegates and Senate Finance Committees, or their designees,  
17 are nonvoting, ex officio members;

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

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 ~~(c)(4)~~ (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 who shall be nonvoting and who is chosen by the West Virginia  
46 Association of Health Plans who shall represent a managed care organization and who is  
47 currently providing services to the Bureau for Medical Services;

48 ~~(D)~~ (E) One member chosen from a list of three persons nominated by the Behavioral  
49 Health Providers Association of West Virginia; and

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

54 (c) No member of the council may be a registered lobbyist.

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

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

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

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

69           (h) The council shall retain the services of an impartial, professional actuary, with  
70 demonstrated experience in analysis of large group health insurance plans, to estimate the total  
71 financial requirements of the Bureau for Medical Services for each fiscal year and to review and  
72 render written professional opinions as to financial plans proposed by the council. The actuary  
73 shall also assist in the development of alternative financing options and perform any other  
74 services requested by the council, the secretary, or the commissioner. All reasonable fees and  
75 expenses for actuarial services shall be paid by the Bureau for Medical Services.

## **ARTICLE 5. MISCELLANEOUS PROVISIONS.**

### **§9-5-34. Medicaid quality measures and cost containment.**

1           The Commissioner for the Bureau for Medical Services shall make every effort to evaluate  
2 and administer programs to improve quality, improve health status of members, develop  
3 innovative payment methodologies, manage health care delivery costs, evaluate effective benefit  
4 designs, evaluate cost sharing and benefit-based programs, and adopt effective industry  
5 programs that can manage the long-term effectiveness and costs for the Medicaid program, but  
6 not be limited to:

- 7           (1) Increasing generic fill rates;  
8           (2) Managing specialty pharmacy costs;  
9           (3) Implementing and evaluating medical home models and health care delivery;  
10           (4) Coordinating with providers, private insurance carriers, and, to the extent possible,  
11 Medicare to encourage the establishment of cost-effective accountable care organizations;  
12           (5) Exploring and developing advanced payment methodologies for care delivery such as  
13 case rates, managed care, capitation, and other potential risk-sharing models and partial risk-  
14 sharing models for accountable care organizations and medical homes;

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

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

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

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

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

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

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

33           (13) Identifying expenditure reduction opportunities to curtail benefits and eligible  
34 populations in line with parameters approved by the Centers for Medicare and Medicaid Services  
35 in other jurisdictions;

36           (14) Analyzing the Medicaid six-year plan concerning assumptions that formulate  
37 expenditure projections with the purpose of crafting strategies to mitigate long-term financial  
38 liabilities in the program.