WEST VIRGINIA CODE: §9-5-22

§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 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 non-network 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.