WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Introduced

House Bill 3276

BY DELEGATE BATES

[Introduced March 16, 2021; Referred to the

Committee on Health and Human Resources]

1 A BILL to amend the Code of West Virginia, 1931, as amended, to amend and reenact §9-5-22
2 of said code to require managed care organizations to report certain mental health parity
3 information; to amend said code by adding thereto a new section, designated §9-5-29,
4 requiring contracts between managed care organizations and the state Medicaid agency
5 to contain certain provisions mandating such managed care organizations to provide
6 mental health parity between behavioral health, mental health, substance use disorders,
7 and medical and surgical procedures; providing definitions; providing for liquidated
8 damages; and setting forth an effective date.

Be it enacted by the Legislature of West Virginia:

CHAPTER 9. HUMAN SERVICES.

ARTICLE 5. MISCELLANEOUS PROVISIONS

§9-5-22. Medicaid managed care reporting.

1 (a) Beginning January 1, 2016, and annually thereafter, the Bureau for Medical Services
2 shall submit an annual report by May of that year to the Joint Committee on Government and
3 Finance and the Legislative Oversight Commission on Health and Human Resources
4 Accountability that includes, but is not limited to, the following information for all managed care
5 organizations:
6 (1) The name and geographic service area of each managed care organization that has
7 contracted with the bureau.
8 (2) The total number of health care providers in each managed care organization broken
9 down by provider type and specialty and by each geographic service area.
10 (3) The monthly average and total of the number of members enrolled in each organization
11 broken down by eligibility group.
12 (4) The percentage of clean claims paid each provider type within 30 calendar days and
13 the average number of days to pay all claims for each managed care organization.

14 (5) The number of claims denied or pended by each managed care organization.

15 (6) The number and dollar value of all claims paid to nonnetwork providers by claim type
16 for each managed care organization.

17 (7) The number of members choosing the managed care organization and the number of
18 members auto-enrolled into each managed care organization, broken down by managed care
19 organization.

20 (8) The amount of the average per member per month payment and total payments paid
21 to each managed care organization.

22 (9) A comparison of nationally recognized health outcomes measures as required by the
23 contracts the managed care organizations have with the bureau.

24 (10) A copy of the member and provider satisfaction survey report for each managed care
25 organization.

26 (11) A copy of the annual audited financial statements for each managed care
27 organization.

28 (12) A brief factual narrative of any sanctions levied by the department against a managed
29 care network.

30 (13) The number of members, broken down by each managed care organization, filing a
31 grievance or appeal and the total number and percentage of grievances or appeals that reversed
32 or otherwise resolved a decision in favor of the member.

33 (14) The number of members receiving unduplicated outpatient emergency services and
34 urgent care services, broken down by managed care organization.

35 (15) The number of total inpatient Medicaid days broken down by managed care
36 organization and aggregated by facility type.

37 (16) The following information concerning pharmacy benefits broken down by each
38 managed care organization and by month:

39 (A) Total number of prescription claims;

40 (B) Total number of prescription claims denied;

41 (C) Average adjudication time for prescription claims;

42 (D) Total number of prescription claims adjudicated within 30 days;

43 (E) Total number of prescription claims adjudicated within 90 days;

44 (F) Total number of prescription claims adjudicated after 30 days; and

45 (G) Total number of prescription claims adjudicated after 90 days.

46 (17) The total number of authorizations by service.

47 (18) The following information concerning mental health parity:

48 (A) Data that demonstrates parity compliance for adverse determination regarding claims
49 for behavioral health, mental health, or substance use disorder services and includes the total
50 number of adverse determinations for such claims;

51 (B) A description of the process used to develop and select:

52 (i) The medical necessity criteria used in determining benefits for behavioral health, mental
53 health, and substance use disorders; and

54 (ii) The medical necessity criteria used in determining medical and surgical benefits;

55 (C) Identification of all nonquantitative treatment limitations that are applied to benefits for
56 behavioral health, mental health, and substance use disorders and to medical and surgical
57 benefits within each classification of benefits; and

58 (D) The results of analyses demonstrating that, for medical necessity criteria described in
59 subdivision (A) of this subsection and for each nonquantitative treatment limitation identified in
60 subdivision (C) of this subsection, as written and in operation, the processes, strategies,
61 evidentiary standards, or other factors used in applying the medical necessity criteria and each
62 nonquantitative treatment limitation to benefits for behavioral health, mental health, and
63 substance use disorders within each classification of benefits are comparable to, and are applied
64 no more stringently than, the processes, strategies, evidentiary standards, or other factors used
65 in applying the medical necessity criteria and each nonquantitative treatment limitation to medical

and surgical benefits within the corresponding classification of benefits.

(E) Identifying factors used to determine whether a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(F) Identifying and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(G) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

(H) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral health, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(I) Disclose the specific findings and conclusions reached by the Bureau of Medical Services that the results of the analyses indicate that each managed care plan provides for mental health parity in compliance with state and federal requirements.

~~(18)~~ (19) Any other metric or measure which the Bureau of Medical Services deems appropriate for inclusion in the report.

~~(19)~~ (20) 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)~~ (21) 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.

§9-5-29. Mental Health Parity Requirement for Managed Care Organization Contracts.

(a) As used in this section, the following words and phrases have the meaning given them in this section unless the context clearly indicates otherwise:

(1) To the extent that coverage is provided, “behavioral health, mental health, and substance use disorder” means a condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of:

(i) The International Statistical Classification of Diseases and Related Health Problems;

(ii) The Diagnostic and Statistical Manual of Mental Disorders; or

9 (iii) The Diagnostic Classification of Mental Health and Developmental Disorders of
10 Infancy and Early Childhood; and
11 Includes autism spectrum disorder: *Provided*, That any service, even if it is related to the
12 behavioral health, mental health, or substance use disorder diagnosis if medical in nature, shall
13 be reviewed as a medical claim and undergo all utilization review as applicable.
14 (2) "Managed care organization" means any organization which provides (or seeks to
15 provide) for the delivery of Medicaid health benefits and additional services through contracted
16 arrangements with the state Medicaid agency.
17 (b) All contracts between managed care organizations and the state Medicaid agency shall
18 include the following requirements relating to mental health parity:
19 (1) The managed care organization is required to provide coverage for the prevention of,
20 screening for, and treatment of behavioral health, mental health, and substance use disorders
21 that is no less extensive than the coverage provided for any physical illness and that complies
22 with the requirements of this section. This screening shall include, but is not limited to, unhealthy
23 alcohol use for adults, substance use for adults and adolescents, and depression screening for
24 adolescents and adults.
25 (2) The managed care organization shall:
26 (i) Include coverage and reimbursement for behavioral health screenings using a validated
27 screening tool for behavioral health, which coverage and reimbursement is no less extensive than
28 the coverage and reimbursement for the annual physical examination;
29 (ii) Comply with the nonquantitative treatment limitation requirements specified in 45
30 C.F.R. §146.136(c)(4), or any successor regulation, regarding any limitations that are not
31 expressed numerically but otherwise limit the scope or duration of benefits for treatment, which in
32 addition to the limitations and examples listed in 45 C.F.R. §146.136(c)(4)(ii) and (c)(4)(iii), or any
33 successor regulation and 78 FR 68246, include the methods by which the managed care
34 organization establishes and maintains its provider network and responds to deficiencies in the

35 ability of its networks to provide timely access to care;

36 (iii) Comply with the financial requirements and quantitative treatment limitations specified

37 in 45 C.F.R. §146.136(c)(2) and (c)(3), or any successor regulation;

38 (iv) Not apply any nonquantitative treatment limitations to benefits for behavioral health,

39 mental health, and substance use disorders that are not applied to medical and surgical benefits

40 within the same classification of benefits;

41 (v) Establish procedures to authorize treatment with a nonparticipating provider if a

42 covered service is not available within established time and distance standards and within a

43 reasonable period after service is requested, and with the same coinsurance, deductible, or

44 copayment requirements as would apply if the service were provided at a participating provider,

45 and at no greater cost to the covered person than if the services were obtained at, or from a

46 participating provider;

47 (3) If a Medicaid beneficiary obtains a covered service from a nonparticipating provider

48 because the covered service is not available within the established time and distance standards,

49 reimburse treatment or services for behavioral health, mental health, or substance use disorders

50 required to be covered pursuant to this subsection that are provided by a nonparticipating provider

51 using the same methodology that the managed care organization uses to reimburse covered

52 medical services provided by nonparticipating providers and, upon request, provide evidence of

53 the methodology to the person or provider.

54 (4) If the managed care organization offers a plan that does not cover services provided

55 by an out-of-network provider, it may provide the benefits required in subsection (b)(2) of this

56 section if the services are rendered by a provider who is designated by and affiliated with the

57 managed care organization only if the same requirements apply for services for a physical illness.

58 (5) In the event of a concurrent review for a claim for coverage of services for the

59 prevention of, screening for, and treatment of behavioral health, mental health, and substance

60 use disorders, the service continues to be a covered service until the managed care organization

61 notifies the Medicaid beneficiary of the determination of the claim.

62 (6) Unless denied for nonpayment of premium, a denial of reimbursement for services for
63 the prevention of, screening for, or treatment of behavioral health, mental health, and substance
64 use disorders by the managed care organization must include the following language:

65 (i) A statement explaining that Medicaid beneficiaries are protected under this section,
66 which provides that limitations placed on the access to mental health and substance use disorder
67 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

68 (ii) A statement providing that the state Medicaid agency can be contacted if a Medicaid
69 beneficiary believes his or her rights under this section have been violated; and

70 (iii) A statement specifying that Medicaid beneficiaries are entitled, upon request to the
71 managed care organization, to a copy of the medical necessity criteria for any behavioral health,
72 mental health, and substance use disorder benefit.

73 (c) The state Medicaid agency shall enforce this section and may conduct a financial
74 examination of the managed care organization to determine if it is in compliance with this section,
75 including, but not limited to, a review of policies and procedures and a sample of mental health
76 claims to determine these claims are treated in parity with medical and surgical benefits. The
77 results of this examination shall be reported to the Legislature. Contracts between the state
78 Medicaid agency and managed care organizations shall set forth liquidated damages to be
79 assessed against managed care organizations which violate this section.

80 (d) This section is effective for all contracts between the state Medicaid agency and
81 managed care organizations delivered, executed, issued, amended, adjusted, or renewed
82 beginning on or after January 1, 2022.

NOTE: The purpose of this bill is to require managed care organizations to report certain mental health parity information and to require contracts between managed care organizations and the state Medicaid agency to contain certain provisions mandating such managed care organizations to provide mental health parity between behavioral health, mental health, substance use disorders, and medical and surgical procedures.

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