WEST VIRGINIA LEGISLATURE

2021 REGULAR SESSION

Introduced

House Bill 2875

BY DELEGATE BATES

[Introduced March 03, 2021; Referred to the

Committee on Health and Human Resources then the

Judiciary]

A BILL to amend and reenact §16-2L-3 and §33-45-2 of the Code of West Virginia, 1931, as amended, relating to changes to provider contracts with health benefit plans and Medicaid managed care plans; providing a notice and negotiation process for changes to provider and Medicaid managed provider contracts providing a notice and negotiation process for changes to health benefit insurer and provider contracts.

Be it enacted by the Legislature of West Virginia:

CHAPTER 16. PUBLIC HEALTH.

ARTICLE 2L. PROVIDER SPONSORED NETWORKS.

§16-2L-3. Contracts with provider sponsored networks.

(a) The secretary is authorized to enter into contracts with any provider sponsored network licensed by the insurance commissioner in accordance with the provisions of §33-25G-1 *et seq*. of this code, to arrange for the provision of health care, services and supplies for Medicaid beneficiaries. Such contract:

(1) Shall be subject to the same criteria and standards applied to other managed care organizations; and

(2) May provide that the provider sponsored network will share with the department up to 25% of any net profits realized during the period of the contract.

(b) The service, administrative, and performance criteria to be met by provider sponsored networks shall be the same as required of other managed care organizations providing services to Medicaid beneficiaries in the state.

(c) A licensed provider sponsored network shall be deemed an HMO for the purposes of federal regulations governing the Medicaid program to the extent permitted by such regulations.

(d) The secretary shall establish procedures for changing an existing agreement with a participating provider that shall include:

(1) A material change to an agreement with a provider must have 90 days notice of the

material change which shall include:

(A) The proposed change effective date;

(B) A description of the material change;

(C) A statement that the provider has the option to accept or reject the change;

(D) Contact information for direct contact with the secretary, to discuss the change, if requested by the provider;

(E) Notice of the opportunity for meeting using real-time communication, such as telephone or video conferencing, to discuss the proposed change;

(F) Notice that upon three material changes in a 12-month period, the provider may request a copy of the contract with the material changes consolidated into it: *Provided*, That issuance of this contract shall be for information purpose and shall have no effect on the terms and conditions of the contract.

(2) If a material change relates to the participating provider's inclusion of new or modified insurance products or proposed changes to the provider's membership networks:

(A) The material change shall take effect only upon acceptance of the participating provider, evidenced by written signature;

(B) The notice of the proposed material change shall be sent by certified mail, return receipt requested.

(3) For a material change not addressed in §33-45-2(d)(2) of this code,

(A) The material change shall take effect on the date provided in the notice unless the provider objects;

(B) A provider who objects under this section shall do so within 30 days of receipt of the notice;

(C) Within 30 days following receipt of notice of the objection, the secretary and provider shall confer in an effort to reach an agreement regarding the proposed change or counter-proposals offered;

(D) If the provider and secretary fail to reach an agreement during this 30-day negotiation period, 30 days shall be allowed for the partied to unwind their relationship, provide notice to patients and other affected parties, and terminated their contract pursuant to its original provisions.

(4) The notice of the proposed material change shall be sent in an orange-colored envelope with the phrase “ATTENTION! CONTRACT AMENDMENT ENCLOSED!” and in no less than 14-point font, bold face, Times New Roman, on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer.

(5) Any notice required under this subsection shall be mailed to the provider’s point of contact as set forth in the providing agreement, the secretary shall send the requisite notice to the provider’s place of business, addressed to the provider.

CHAPTER33. INSURANCE.

ARTICLE 45. ETHICS AND FAIRNESS IN INSURER BUSINESS PRACTICES.

§33-45-2. Minimum fair business standards contract provisions required; processing and payment of health care services; provider claims; commissioner’s jurisdiction.

(a) Every provider contract entered into, amended, extended, or renewed by an insurer on or after August 1, 2001, shall contain specific provisions which shall require the insurer to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

(1) An insurer shall either pay or deny a clean claim within 40 days of receipt of the claim if submitted manually and within 30 days of receipt of the claim if submitted electronically, except in the following circumstances:

(A) Another payor or party is responsible for the claim;

(B) The insurer is coordinating benefits with another payor;

(C) The provider has already been paid for the claim;

(D) The claim was submitted fraudulently; or

(E) There was a material misrepresentation in the claim.

(2) Each insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If an insurer fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

(3) An insurer shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within 15 days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an insurer shall either pay or deny the claim within 30 days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the insurer fails to timely notify the person submitting the claim within 30 days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims: *Provided,* That nothing herein shall preclude such an insurer from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate §33-45-2(a)(7) of this code.

This subsection does not require an insurer to pay a claim that is not a clean claim except as provided herein.

(4) Interest, at a rate of 10 percent per annum, accruing after the 40-day period provided in §33-45-2(a)(1) of this code owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within 30 days thereafter.

(5) Every insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(A) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and

(B) To determine the insurer's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for:

(i) Precertification or authorization of coverage decisions;

(ii) Retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim;

(iii) Provider-specific payment and reimbursement methodology; and

(iv) Other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim.

(C) Every insurer shall make available to the provider within 20 business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by

the provider.

(6) Every insurer shall pay a clean claim if the insurer has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(A) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

(B) The insurer's refusal is because:

(i) Another payor or party is responsible for the payment;

(ii) The provider has already been paid for the health care services identified on the claim;

(iii) The claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by the provider, enrollee, or other person not related to the insurer;

(iv) The person receiving the health care services was not eligible to receive them on the date of service and the insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;

(v) There is a dispute regarding the amount of charges submitted; or

(vi) The service provided was not a covered benefit and the insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

(7) A previously paid claim may be retroactively denied only in accordance with this subdivision.

(A) No insurance company may retroactively deny a previously paid claim unless:

(i) The claim was submitted fraudulently;

(ii) The claim contained material misrepresentations;

(iii) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by the provider;

(iv) The provider was not entitled to reimbursement;

(v) The service provided was not covered by the health benefit plan; or

(vi) The insured was not eligible for reimbursement.

(B) A provider to whom a previously paid claim has been denied by a health plan in accordance with this section shall, upon receipt of notice of retroactive denial by the plan, notify the health plan within 40 days of the provider's intent to pay or demand written explanation of the reasons for the denial.

(i) Upon receipt of explanation for retroactive denial, the provider shall reimburse the plan within 30 days for allowing an offset against future payments or provide written notice of dispute.

(ii) Disputes shall be resolved between the parties within 30 days of receipt of notice of dispute. The parties may agree to a process to resolve the disputes in a provider contract.

(iii) Upon resolution of dispute, the provider shall pay any amount due or provide written authorization for an offset against future payments.

(C) A health plan may retroactively deny a claim only for the reasons set forth in §33-45-2(a)(7)(A)(iii) through §33-45-2(a)(7)(A)(vi) of this code for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth in §33-45-2(a)(7)(A)(i) and §33-45-2(a)(7)(A)(ii) of this code.

(8) No provider contract may fail to include or attach at the time it is presented to the provider for execution:

(A) The fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis; and

(B) All material addenda, schedules, and exhibits thereto applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

~~(9) No amendment to any provider contract or to any addenda, schedule, or exhibit, or~~

~~new addenda, schedule, exhibit, applicable to the provider to the extent that any of them involve payment or delivery of care by the provider, or to the range of health care services reasonably expected to be delivered by that type of provider, is effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment, or of the proposed new addenda, schedule, or exhibit, and has failed to notify the insurer within 20 business days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract~~

~~(11)~~ (10) The insurer shall complete a credential check of any new provider and accept or reject the provider within four months following the submission of the provider's completed application*: Provided,* That time frame may be extended for an additional three months because of delays in primary source verification. The insurer shall make available to providers a list of all information required to be included in the application. A provider who provides services during the credentialing period shall be paid for the services: *Provided*, That nothing in this subdivision prevents an insurer from obtaining refund of overpayments to a provider when the provider fails to become credentialed after having gone through the credentialing process.

~~(10)~~ (11) In the event that the insurer's provision of a policy required to be provided under §33-45-2(a)(8) and §33-45-2(a)(9) of this code would violate any applicable copyright law, the insurer may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

(b) Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every insurer subject to regulation by this article shall adhere to and comply with the minimum fair business standards required under §33-45-2(a) of this code. The commissioner has jurisdiction to determine if an insurer has violated the standards set forth in §33-45-2(a) of this code by failing to include the requisite provisions in its provider contracts. The commissioner has jurisdiction to determine if the insurer has failed to implement the minimum fair business standards

set out in §33-45-2(a)(1) and §33-45-2(a)(2) of this code in the performance of its provider contracts.

(c) Each insurer shall establish procedures for changing an existing agreement with a participating provider that shall include:

(1) A material change to an agreement with a provider must have 90 days notice of the material change which shall include:

(A) The proposed change effective date;

(B) A description of the material change;

(C) A statement that the provider has the option to accept of reject the change;

(D) The name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the material change, if requested by the provider;

(E) Notice of the opportunity for meeting using real-time communication, such as telephone or video conferencing, to discuss the proposed change;

(F) Notice that upon three material changes in a 12-month period, the provider may request a copy of the contract with the material changes consolidated into it; *Provided*, issuance of this contract shall be for information purpose and shall have no effect on the terms and conditions of the contract.

(2) If a material change relates to the participating provider's inclusion of new or modified insurance products, or proposed changes to the provider's membership networks:

(A) The material change shall take effect only upon acceptance of the participating provider, evidenced by written signature;

(B) The notice of the proposed material change shall be sent by certified mail, return receipt requested.

(3) For a material change not addressed in subsection (c)(2) of this section,

(A) The material change shall take effect on the date provided in the notice unless the provider objects;

(B) A participating provider who objects under this section shall do so within 30 days of receipt of the notice;

(C) Within 30 days following receipt of notice of the objection, the insurer and provider shall confer in an effort to reach an agreement regarding the proposed change or counter-proposals offered;

(D) If the provider and insurer fail to reach an agreement during this 30-day negotiation period, 30 days shall be allowed for the partied to unwind their relationship, provide notice to patients and other affected parties, and terminated their contract pursuant to its original provisions.

(4) The notice of the proposed material change shall be sent in an orange-colored envelope with the phrase “ATTENTION! CONTRACT AMENDMENT ENCLOSED!” and in no less than 14-point font, bold face, Times New Roman, on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed material changes and shall not be used for other types of communication from an insurer.

(5) Any notice required under this subsection shall be mailed to the provider’s point of contact as set forth in the providing agreement, the insurer shall send the requisite notice to the provider’s place of business, addressed to the provider.

~~(c)~~ (d) No insurer is in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the insurer’s compliance is rendered impossible due to matters beyond the insurer’s reasonable control, such as an act of God, insurrection, strike, fire, or power outages, which are not caused in material part by the insurer.

NOTE: The purpose of this bill is to provide a notice and compromise process for material changes to contracts between providers and health benefit plans and Medicaid managed care plans.

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