

WEST VIRGINIA LEGISLATURE

2024 REGULAR SESSION

Committee Substitute

for

Senate Bill 313

By Senators Chapman, Rucker, and Grady

[Originating in the Committee on Health and Human

Resources; reported January 29, 2024]

1 A BILL to amend and reenact §5-16-7 of the Code of West Virginia, 1931, as amended; to amend
2 and reenact §9-1-2 of said code; and to amend and reenact §9-5-12 of said code, all
3 relating to allowing for doula reimbursement under the West Virginia Public Employees
4 Insurance Act and Medicaid.

Be it enacted by the Legislature of West Virginia:

**CHAPTER 5. GENERAL POWERS AND AUTHORITY OF THE
GOVERNOR, SECRETARY OF STATE AND ATTORNEY GENERAL;
BOARD OF PUBLIC WORKS; MISCELLANEOUS AGENCIES,
COMMISSIONS, OFFICES, PROGRAMS, ETC**

ARTICLE 16. WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE ACT

**§5-16-7. Authorization to establish plans; mandated benefits; optional plans; separate
rating for claims experience purposes.**

1 (a) The agency shall establish plans for those employees herein made eligible and
2 establish and promulgate rules for the administration of these plans subject to the limitations
3 contained in this article. These plans shall include:

4 (1) Coverages and benefits for x-ray and laboratory services in connection with
5 mammograms when medically appropriate and consistent with current guidelines from the United
6 States Preventive Services Task Force; pap smears, either conventional or liquid-based cytology,
7 whichever is medically appropriate and consistent with the current guidelines from either the
8 United States Preventive Services Task Force or the American College of Obstetricians and
9 Gynecologists; and a test for the human papilloma virus when medically appropriate and
10 consistent with current guidelines from either the United States Preventive Services Task Force or
11 the American College of Obstetricians and Gynecologists, when performed for cancer screening
12 or diagnostic services on a woman age 18 or over;

13 (2) Annual checkups for prostate cancer in men age 50 and over;

14 (3) Annual screening for kidney disease as determined to be medically necessary by a
15 physician using any combination of blood pressure testing, urine albumin or urine protein testing,
16 and serum creatinine testing as recommended by the National Kidney Foundation;

17 (4) For plans that include maternity benefits, coverage for inpatient care in a duly licensed
18 health care facility for a mother and her newly born infant for the length of time which the attending
19 physician considers medically necessary for the mother or her newly born child. No plan may deny
20 payment for a mother or her newborn child prior to 48 hours following a vaginal delivery or prior to
21 96 hours following a caesarean section delivery if the attending physician considers discharge
22 medically inappropriate. Any plans that include maternity benefits will include coverage for
23 mothers who choose to use doulas. A "doula" means a trained professional providing continuous
24 physical, emotional, and informational support during pregnancy, throughout the antepartum,
25 intrapartum, and postpartum periods. Doula services may be provided from the date of confirmed
26 conception through 180 days after delivery, contingent on the client maintaining eligibility. Doulas
27 will be reimbursed for their services at rates commensurate with the depth and complexity of the
28 medical support offered.

29 (5) For plans which provide coverages for post-delivery care to a mother and her newly
30 born child in the home, coverage for inpatient care following childbirth as provided in subdivision
31 (4) of this subsection if inpatient care is determined to be medically necessary by the attending
32 physician. These plans may include, among other things, medicines, medical equipment,
33 prosthetic appliances, and any other inpatient and outpatient services and expenses considered
34 appropriate and desirable by the agency; and

35 (6) Coverage for treatment of serious mental illness:

36 (A) The coverage does not include custodial care, residential care, or schooling. For
37 purposes of this section, "serious mental illness" means an illness included in the American
38 Psychiatric Association's diagnostic and statistical manual of mental disorders, as periodically

39 revised, under the diagnostic categories or subclassifications of:

40 (i) Schizophrenia and other psychotic disorders;

41 (ii) Bipolar disorders;

42 (iii) Depressive disorders;

43 (iv) Substance-related disorders with the exception of caffeine-related disorders and
44 nicotine-related disorders;

45 (v) Anxiety disorders; and

46 (vi) Anorexia and bulimia.

47 With regard to a covered individual who has not yet attained the age of 19 years, "serious
48 mental illness" also includes attention deficit hyperactivity disorder, separation anxiety disorder,
49 and conduct disorder.

50 (B) The agency shall not discriminate between medical-surgical benefits and mental health
51 benefits in the administration of its plan. With regard to both medical-surgical and mental health
52 benefits, it may make determinations of medical necessity and appropriateness and it may use
53 recognized health care quality and cost management tools including, but not limited to, limitations
54 on inpatient and outpatient benefits, utilization review, implementation of cost-containment
55 measures, preauthorization for certain treatments, setting coverage levels, setting maximum
56 number of visits within certain time periods, using capitated benefit arrangements, using fee-for-
57 service arrangements, using third-party administrators, using provider networks, and using patient
58 cost sharing in the form of copayments, deductibles, and coinsurance. Additionally, the agency
59 shall comply with the financial requirements and quantitative treatment limitations specified in 45
60 CFR 146.136(c)(2) and (c)(3), or any successor regulation. The agency may not apply any
61 nonquantitative treatment limitations to benefits for behavioral health, mental health, and
62 substance use disorders that are not applied to medical and surgical benefits within the same
63 classification of benefits: *Provided*, That any service, even if it is related to the behavioral health,
64 mental health, or substance use diagnosis if medical in nature, shall be reviewed as a medical

65 claim and undergo all utilization review as applicable;

66 (7) Coverage for general anesthesia for dental procedures and associated outpatient
67 hospital or ambulatory facility charges provided by appropriately licensed health care individuals in
68 conjunction with dental care if the covered person is:

69 (A) Seven years of age or younger or is developmentally disabled and is an individual for
70 whom a successful result cannot be expected from dental care provided under local anesthesia
71 because of a physical, intellectual, or other medically compromising condition of the individual and
72 for whom a superior result can be expected from dental care provided under general anesthesia.

73 (B) A child who is 12 years of age or younger with documented phobias or with
74 documented mental illness and with dental needs of such magnitude that treatment should not be
75 delayed or deferred and for whom lack of treatment can be expected to result in infection, loss of
76 teeth, or other increased oral or dental morbidity and for whom a successful result cannot be
77 expected from dental care provided under local anesthesia because of such condition and for
78 whom a superior result can be expected from dental care provided under general anesthesia.

79 (8)(A) All plans shall include coverage for diagnosis, evaluation, and treatment of autism
80 spectrum disorder in individuals ages 18 months to 18 years. To be eligible for coverage and
81 benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at
82 age eight or younger. Such plan shall provide coverage for treatments that are medically
83 necessary and ordered or prescribed by a licensed physician or licensed psychologist and in
84 accordance with a treatment plan developed from a comprehensive evaluation by a certified
85 behavior analyst for an individual diagnosed with autism spectrum disorder.

86 (B) The coverage shall include, but not be limited to, applied behavior analysis which shall
87 be provided or supervised by a certified behavior analyst. This subdivision does not limit, replace,
88 or affect any obligation to provide services to an individual under the Individuals with Disabilities
89 Education Act, 20 U. S. C. §1400 *et seq.*, as amended from time to time, or other publicly funded
90 programs. Nothing in this subdivision requires reimbursement for services provided by public

91 school personnel.

92 (C) The certified behavior analyst shall file progress reports with the agency semiannually.

93 In order for treatment to continue, the agency must receive objective evidence or a clinically
94 supportable statement of expectation that:

95 (i) The individual's condition is improving in response to treatment;

96 (ii) A maximum improvement is yet to be attained; and

97 (iii) There is an expectation that the anticipated improvement is attainable in a reasonable
98 and generally predictable period of time.

99 (D) To the extent that the provisions of this subdivision require benefits that exceed the
100 essential health benefits specified under section 1302(b) of the Patient Protection and Affordable
101 Care Act, Pub. L. No. 111-148, as amended, the specific benefits that exceed the specified
102 essential health benefits shall not be required of insurance plans offered by the Public Employees
103 Insurance Agency.

104 (9) For plans that include maternity benefits, coverage for the same maternity benefits for
105 all individuals participating in or receiving coverage under plans that are issued or renewed on or
106 after January 1, 2014: *Provided*, That to the extent that the provisions of this subdivision require
107 benefits that exceed the essential health benefits specified under section 1302(b) of the Patient
108 Protection and Affordable Care Act, Pub. L. No. 111-148, as amended, the specific benefits that
109 exceed the specified essential health benefits shall not be required of a health benefit plan when
110 the plan is offered in this state.

111 (10)(A) Coverage, through the age of 20, for amino acid-based formula for the treatment of
112 severe protein-allergic conditions or impaired absorption of nutrients caused by disorders affecting
113 the absorptive surface, function, length, and motility of the gastrointestinal tract. This includes the
114 following conditions, if diagnosed as related to the disorder by a physician licensed to practice in
115 this state pursuant to either §30-3-1 *et seq.* or §30-14-1 *et seq.* of this code:

116 (i) Immunoglobulin E and nonimmunoglobulin E-medicated allergies to multiple food

117 proteins;

118 (ii) Severe food protein-induced enterocolitis syndrome;

119 (iii) Eosinophilic disorders as evidenced by the results of a biopsy; and

120 (iv) Impaired absorption of nutrients caused by disorders affecting the absorptive surface,
121 function, length, and motility of the gastrointestinal tract (short bowel).

122 (B) The coverage required by paragraph (A) of this subdivision shall include medical foods
123 for home use for which a physician has issued a prescription and has declared them to be
124 medically necessary, regardless of methodology of delivery.

125 (C) For purposes of this subdivision, "medically necessary foods" or "medical foods" shall
126 mean prescription amino acid-based elemental formulas obtained through a pharmacy: *Provided*,
127 That these foods are specifically designated and manufactured for the treatment of severe allergic
128 conditions or short bowel.

129 (D) The provisions of this subdivision shall not apply to persons with an intolerance for
130 lactose or soy.

131 (11) The cost for coverage of children's immunization services from birth through age 16
132 years to provide immunization against the following illnesses: Diphtheria, polio, mumps, measles,
133 rubella, tetanus, hepatitis-b, hemophilia influenzae-b, and whooping cough. Any contract entered
134 into to cover these services shall require that all costs associated with immunization, including the
135 cost of the vaccine, if incurred by the health care provider, and all costs of vaccine administration
136 be exempt from any deductible, per visit charge, and copayment provisions which may be in force
137 in these policies or contracts. This section does not require that other health care services
138 provided at the time of immunization be exempt from any deductible or copayment provisions.

139 (12) The provision requiring coverage for 12-month refill for contraceptive drugs codified at
140 §33-58-1 of this code.

141 (13) The group life and accidental death insurance herein provided shall be in the amount
142 of \$10,000 for every employee.

143 (b) The agency shall make available to each eligible employee, at full cost to the employee,
144 the opportunity to purchase optional group life and accidental death insurance as established
145 under the rules of the agency. In addition, each employee is entitled to have his or her spouse and
146 dependents, as defined by the rules of the agency, included in the optional coverage, at full cost to
147 the employee, for each eligible dependent.

148 (c) The finance board may cause to be separately rated for claims experience purposes:

149 (1) All employees of the State of West Virginia;

150 (2) All teaching and professional employees of state public institutions of higher education
151 and county boards of education;

152 (3) All nonteaching employees of the Higher Education Policy Commission, West Virginia
153 Council for Community and Technical College Education, and county boards of education; or

154 (4) Any other categorization which would ensure the stability of the overall program.

155 (d) The agency shall maintain the medical and prescription drug coverage for Medicare-
156 eligible retirees by providing coverage through one of the existing plans or by enrolling the
157 Medicare-eligible retired employees into a Medicare-specific plan, including, but not limited to, the
158 Medicare/Advantage Prescription Drug Plan. If a Medicare-specific plan is no longer available or
159 advantageous for the agency and the retirees, the retirees remain eligible for coverage through the
160 agency.

161 (e) The agency shall establish procedures to authorize treatment with a nonparticipating
162 provider if a covered service is not available within established time and distance standards and
163 within a reasonable period after service is requested, and with the same coinsurance, deductible,
164 or copayment requirements as would apply if the service were provided at a participating provider,
165 and at no greater cost to the covered person than if the services were obtained at or from a
166 participating provider.

167 (f) If the Public Employees Insurance Agency offers a plan that does not cover services
168 provided by an out-of-network provider, it may provide the benefits required in paragraph (A),

169 subdivision (6), subsection (a) of this section if the services are rendered by a provider who is
170 designated by and affiliated with the Public Employees Insurance Agency, and only if the same
171 requirements apply for services for a physical illness.

172 (g) In the event of a concurrent review for a claim for coverage of services for the
173 prevention of, screening for, and treatment of behavioral health, mental health, and substance use
174 disorders, the service continues to be a covered service until the Public Employees Insurance
175 Agency notifies the covered person of the determination of the claim.

176 (h) Unless denied for nonpayment of premium, a denial of reimbursement for services for
177 the prevention of, screening for, or treatment of behavioral health, mental health, and substance
178 use disorders by the Public Employees Insurance Agency shall include the following language:

179 (1) A statement explaining that covered persons are protected under this section, which
180 provides that limitations placed on the access to mental health and substance use disorder
181 benefits may be no greater than any limitations placed on access to medical and surgical benefits;

182 (2) A statement providing information about the internal appeals process if the covered
183 person believes his or her rights under this section have been violated; and

184 (3) A statement specifying that covered persons are entitled, upon request to the Public
185 Employees Insurance Agency, to a copy of the medical necessity criteria for any behavioral health,
186 mental health, and substance use disorder benefit.

187 (i) On or after June 1, 2021, and annually thereafter, the Public Employees Insurance
188 Agency shall submit a written report to the Joint Committee on Government and Finance that
189 contains the following information regarding plans offered pursuant to this section:

190 (1) Data that demonstrates parity compliance for adverse determination regarding claims
191 for behavioral health, mental health, or substance use disorder services and includes the total
192 number of adverse determinations for such claims;

193 (2) A description of the process used to develop and select:

194 (A) The medical necessity criteria used in determining benefits for behavioral health,

195 mental health, and substance use disorders; and

196 (B) The medical necessity criteria used in determining medical and surgical benefits;

197 (3) Identification of all nonquantitative treatment limitations that are applied to benefits for
198 behavioral health, mental health, and substance use disorders and to medical and surgical
199 benefits within each classification of benefits;

200 (4) The results of analyses demonstrating that, for medical necessity criteria described in
201 subdivision (2) of this subsection and for each nonquantitative treatment limitation identified in
202 subdivision (3) of this subsection, as written and in operation, the processes, strategies,
203 evidentiary standards, or other factors used in applying the medical necessity criteria and each
204 nonquantitative treatment limitation to benefits for behavioral health, mental health, and substance
205 use disorders within each classification of benefits are comparable to, and are applied no more
206 stringently than, the processes, strategies, evidentiary standards, or other factors used in applying
207 the medical necessity criteria and each nonquantitative treatment limitation to medical and
208 surgical benefits within the corresponding classification of benefits;

209 (5) The Public Employees Insurance Agency's report of the analyses regarding
210 nonquantitative treatment limitations shall include at a minimum:

211 (A) Identify factors used to determine whether a nonquantitative treatment limitation will
212 apply to a benefit, including factors that were considered but rejected;

213 (B) Identify and define the specific evidentiary standards used to define the factors and any
214 other evidence relied on in designing each nonquantitative treatment limitation;

215 (C) Provide the comparative analyses, including the results of the analyses, performed to
216 determine that the processes and strategies used to design each nonquantitative treatment
217 limitation, as written, and the written processes and strategies used to apply each nonquantitative
218 treatment limitation for benefits for behavioral health, mental health, and substance use disorders
219 are comparable to, and are applied no more stringently than, the processes and strategies used to
220 design and apply each nonquantitative treatment limitation, as written, and the written processes

221 and strategies used to apply each nonquantitative treatment limitation for medical and surgical
222 benefits;

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

229 (E) Disclose the specific findings and conclusions reached by the Public Employees
230 Insurance Agency that the results of the analyses indicate that each health benefit plan offered by
231 the Public Employees Insurance Agency complies with paragraph (B), subdivision (6), subsection
232 (a) of this section; and

233 (6) After the initial report required by this subsection, annual reports are only required for
234 any year thereafter during which the Public Employees Insurance Agency makes significant
235 changes to how it designs and applies medical management protocols.

236 (j) The Public Employees Insurance Agency shall update its annual plan document to
237 reflect its comprehensive parity compliance. An annual report shall also be filed with the Joint
238 Committee on Government and Finance and the Public Employees Insurance Agency Finance
239 Board.

CHAPTER 9. HUMAN SERVICES

ARTICLE 1. LEGISLATIVE PURPOSE AND DEFINITIONS

§9-1-2. Definitions

1 The following words and terms when used in this chapter have the meanings indicated:

2 "Department" means the ~~state division of human services: Provided, That beginning~~
3 ~~January 1, 2024, "department" means the~~ Department of Human Services.

4 "Commissioner" means the ~~commissioner of human services~~: ~~Provided, That beginning~~
5 ~~January 1 2024,~~ "commissioner" means the secretary of the Department of Human Services.

6 "Federal-state assistance" means and includes: (1) All forms of aid, care, assistance and
7 services to or on behalf of persons, which are authorized by, and who are authorized to receive the
8 same under and by virtue of, subchapters one, four, five, ten, fourteen, sixteen, eighteen and
9 nineteen, chapter seven, Title 42, United States Code, as those subchapters have heretofore
10 been and may hereafter be amended, supplemented and revised by acts of Congress, and as
11 those subchapters so amended, supplemented and revised have heretofore been and may
12 hereafter be supplemented by valid rules and regulations promulgated by authorized federal
13 agents and agencies, and as those subchapters so amended, supplemented and revised have
14 heretofore been and may hereafter be supplemented by rules promulgated by the state division of
15 human services or by the Department of Human Services, which rules shall be consistent with
16 federal laws, rules and regulations, but not inconsistent with state law; and (2) all forms of aid,
17 care, assistance and services to persons, which are authorized by, and who are authorized to
18 receive the same under and by virtue of, any act of Congress, other than the federal social security
19 act, as amended, for distribution through the state division of human services or the Department of
20 Human Services to recipients of any form of aid, care, assistance and services to persons
21 designated or referred to in (1) of this definition and to recipients of state assistance, including by
22 way of illustration, surplus food and food stamps, which Congress has authorized the secretary of
23 agriculture of the United States to distribute to needy persons.

24 "Federal assistance" means and includes all forms of aid, care, assistance and services to
25 or on behalf of persons, which are authorized by, and who are authorized to receive the same
26 under and by virtue of, any act of Congress for distribution through the state division of human
27 services or the Department of Human Services, the cost of which is paid entirely out of federal
28 appropriations.

29 "State assistance" means and includes all forms of aid, care, assistance, services and

30 general relief made possible solely out of state, county and private appropriations to or on behalf of
31 indigent persons, which are authorized by, and who are authorized to receive the same under and
32 by virtue of, state division of human services' or Department of Human Services' rules.

33 "Assistance" means the three classes of assistance, namely: Federal-state assistance,
34 federal assistance and state assistance.

35 "Indigent person" means any person who is domiciled in this state and who is actually in
36 need as defined by division or department rules and has not sufficient income or other resources to
37 provide for such need as determined by the state division of human services or the Department of
38 Human Services.

39 "Domiciled in this state" means being physically present in West Virginia accompanied by
40 an intention to remain in West Virginia for an indefinite period of time, and to make West Virginia
41 his or her permanent home. ~~The state division of human services or the~~ Department of Human
42 Services may by rules supplement the foregoing definition of the term "domiciled in this state", but
43 not in a manner as would be inconsistent with federal laws, rules, and regulations applicable to
44 and governing federal-state assistance.

45 "Medical services" means medical, surgical, dental and nursing services, and other
46 remedial services recognized by law, in the home, office, hospital, clinic and any other suitable
47 place, provided or prescribed by persons permitted or authorized by law to give such services; the
48 services to include drugs and medical supplies, appliances, laboratory, diagnostic and therapeutic
49 services, nursing home and convalescent care and such other medical services and supplies as
50 may be prescribed by the persons. This shall include medical services provided by doulas during
51 the birthing process.

52 "Secretary" means ~~the secretary of the Department of Health and Human Resources:~~
53 ~~Provided, That beginning January 1, 2024, "secretary" means the secretary of the Department of~~
54 Human Services.

55 "Estate" means all real and personal property and other assets included within the

56 individual's estate as defined in the state's probate law.

57 "Services" means nursing facility services, home and community-based services, and
58 related hospital and prescription drug services for which an individual received Medicaid medical
59 assistance. This shall include doula services.

60 "State Medicaid agency" means the Bureau for Medical Services that is the federally
61 designated single state agency charged with administration and supervision of the state Medicaid
62 program.

ARTICLE 5 MISCELLANEOUS PROVISIONS.

§9-5-12. Medicaid program; maternity and infant care.

1 (a) The department shall:

2 (1) Extend Medicaid coverage to pregnant women and their newborn infants to 185
3 percent of the federal poverty level and to provide coverage up to one-year postpartum care,
4 effective July 1, 2021, or as soon as federal approval has occurred.

5 (2) As provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA),
6 Public Law 99-272, the Sixth Omnibus Budget Reconciliation Act (SOBRA), Public Law 99-509,
7 and the Omnibus Budget Reconciliation Act (OBRA), Public Law 100-203, effective July 1, 1988,
8 infants shall be included under Medicaid coverage with all children eligible for Medicaid coverage
9 born after October 1, 1983, whose family incomes are at or below 100 percent of the federal
10 poverty level and continuing until such children reach the age of eight years.

11 (3) Elect the federal options provided under COBRA, SOBRA, and OBRA impacting
12 pregnant women and children below the poverty level: *Provided*, That no provision in this article
13 shall restrict the department in exercising new options provided by or to be in compliance with new
14 federal legislation that further expands eligibility for children and pregnant women.

15 (4) The department is responsible for the implementation and program design for a
16 maternal and infant health care system to reduce infant mortality in West Virginia. The health
17 system design shall include quality assurance measures, case management, and patient outreach

18 activities. The department shall assume responsibility for claims processing in accordance with
19 established fee schedules and financial aspects of the program necessary to receive available
20 federal dollars and to meet federal rules and regulations.

21 (5) The department shall increase to no less than \$600 the reimbursement rates under the
22 Medicaid program for prenatal care, delivery, and post-partum care. The department will extend
23 these same reimbursement rates to doulas employed in the delivery process.

24 (6) File a state plan amendment, as preventative services, to extend Medicaid coverage to
25 doula services. A “doula” means a trained professional providing continuous physical, emotional,
26 and informational support during pregnancy, throughout the antepartum, intrapartum, and
27 postpartum periods. Doula services may be provided from the date of confirmed conception
28 through 180 days after delivery, contingent on the client maintaining Medicaid eligibility. The doula
29 services are provided to improve maternal health outcomes. The Bureau for Medical Services
30 shall file the state plan amendment on or before January 1, 2025.

31 (b) In order to be in compliance with the provisions of OBRA through rules and regulations,
32 the department shall ensure that pregnant women and children whose incomes are above the Aid
33 to Families and Dependent Children (AFDC) payment level are not required to apply for
34 entitlements under the AFDC program as a condition of eligibility for Medicaid coverage. Further,
35 the department shall develop a short, simplified pregnancy/pediatric application of no more than
36 three pages, paralleling the simplified OBRA standards.

37 (c) Any woman who establishes eligibility under this section shall continue to be treated as
38 an eligible individual without regard to any change in income of the family of which she is a
39 member until the end of the one-year period beginning on the last day of her pregnancy.

40 (d) The department shall make payment for tubal ligation without requiring at least 30 days
41 between the date of informed consent and the date of the tubal ligation procedure.

NOTE: The purpose of this bill is to require doula services to be covered by Medicaid and PEIA.

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