

By: Muñoz, Jr.

H.B. No. 3464

A BILL TO BE ENTITLED

AN ACT

relating to the processing and payment of claims for reimbursement by providers under the Medicaid program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

1           (5) a requirement that the managed care organization  
2 provide information and referral about the availability of  
3 educational, social, and other community services that could  
4 benefit a recipient;

5           (6) procedures for recipient outreach and education;

6           (7) a requirement that the managed care organization  
7 make payment to a physician or provider for health care services  
8 rendered to a recipient under a managed care plan not later than the  
9 15th [~~45th~~] day after the date a claim for payment is received with  
10 documentation reasonably necessary for the managed care  
11 organization to process the claim[~~, or within a period, not to~~  
12 ~~exceed 60 days, specified by a written agreement between the~~  
13 ~~physician or provider and the managed care organization];~~

14           (7-a) a requirement that the managed care organization  
15 allow a physician or provider to electronically submit  
16 documentation necessary for the managed care organization to  
17 process a claim for payment for health care services rendered to a  
18 recipient under a managed care plan, including additional  
19 documentation necessary when the claim is not submitted with  
20 documentation reasonably necessary for the managed care  
21 organization to process the claim;

22           (8) a requirement that the commission, on the date of a  
23 recipient's enrollment in a managed care plan issued by the managed  
24 care organization, inform the organization of the recipient's  
25 Medicaid certification date;

26           (9) a requirement that the managed care organization  
27 comply with Section [533.006](#) as a condition of contract retention

1 and renewal;

2 (10) a requirement that the managed care organization  
3 provide the information required by Section 533.012 and otherwise  
4 comply and cooperate with the commission's office of inspector  
5 general and the office of the attorney general;

6 (11) a requirement that the managed care  
7 organization's usages of out-of-network providers or groups of  
8 out-of-network providers may not exceed limits for those usages  
9 relating to total inpatient admissions, total outpatient services,  
10 and emergency room admissions determined by the commission;

11 (12) if the commission finds that a managed care  
12 organization has violated Subdivision (11), a requirement that the  
13 managed care organization reimburse an out-of-network provider for  
14 health care services at a rate that is equal to the allowable rate  
15 for those services, as determined under Sections 32.028 and  
16 32.0281, Human Resources Code;

17 (13) a requirement that the organization use advanced  
18 practice nurses in addition to physicians as primary care providers  
19 to increase the availability of primary care providers in the  
20 organization's provider network;

21 (14) a requirement that the managed care organization  
22 reimburse a federally qualified health center or rural health  
23 clinic for health care services provided to a recipient outside of  
24 regular business hours, including on a weekend day or holiday, at a  
25 rate that is equal to the allowable rate for those services as  
26 determined under Section 32.028, Human Resources Code, if the  
27 recipient does not have a referral from the recipient's primary

1 care physician;

2 (15) a requirement that the managed care organization  
3 develop, implement, and maintain a system for tracking and  
4 resolving all provider appeals related to claims payment, including  
5 a process that will require:

6 (A) a tracking mechanism to document the status  
7 and final disposition of each provider's claims payment appeal;

8 (B) the contracting with physicians who are not  
9 network providers and who are of the same or related specialty as  
10 the appealing physician to resolve claims disputes related to  
11 denial on the basis of medical necessity that remain unresolved  
12 subsequent to a provider appeal; and

13 (C) the determination of the physician resolving  
14 the dispute to be binding on the managed care organization and  
15 provider;

16 (16) a requirement that a medical director who is  
17 authorized to make medical necessity determinations is available to  
18 the region where the managed care organization provides health care  
19 services;

20 (17) a requirement that the managed care organization  
21 ensure that a medical director and patient care coordinators and  
22 provider and recipient support services personnel are located in  
23 the South Texas service region, if the managed care organization  
24 provides a managed care plan in that region;

25 (18) a requirement that the managed care organization  
26 provide special programs and materials for recipients with limited  
27 English proficiency or low literacy skills;

1           (19) a requirement that the managed care organization  
2 develop and establish a process for responding to provider appeals  
3 in the region where the organization provides health care services;

4           (20) a requirement that the managed care organization  
5 develop and submit to the commission, before the organization  
6 begins to provide health care services to recipients, a  
7 comprehensive plan that describes how the organization's provider  
8 network will provide recipients sufficient access to:

9                   (A) preventive care;

10                   (B) primary care;

11                   (C) specialty care;

12                   (D) after-hours urgent care; and

13                   (E) chronic care;

14           (21) a requirement that the managed care organization  
15 demonstrate to the commission, before the organization begins to  
16 provide health care services to recipients, that:

17                   (A) the organization's provider network has the  
18 capacity to serve the number of recipients expected to enroll in a  
19 managed care plan offered by the organization;

20                   (B) the organization's provider network  
21 includes:

22                           (i) a sufficient number of primary care  
23 providers;

24                           (ii) a sufficient variety of provider  
25 types; and

26                           (iii) providers located throughout the  
27 region where the organization will provide health care services;

1 and

2 (C) health care services will be accessible to  
3 recipients through the organization's provider network to a  
4 comparable extent that health care services would be available to  
5 recipients under a fee-for-service or primary care case management  
6 model of Medicaid managed care;

7 (22) a requirement that the managed care organization  
8 develop a monitoring program for measuring the quality of the  
9 health care services provided by the organization's provider  
10 network that:

11 (A) incorporates the National Committee for  
12 Quality Assurance's Healthcare Effectiveness Data and Information  
13 Set (HEDIS) measures;

14 (B) focuses on measuring outcomes; and

15 (C) includes the collection and analysis of  
16 clinical data relating to prenatal care, preventive care, mental  
17 health care, and the treatment of acute and chronic health  
18 conditions and substance abuse;

19 (23) subject to Subsection (a-1), a requirement that  
20 the managed care organization develop, implement, and maintain an  
21 outpatient pharmacy benefit plan for its enrolled recipients:

22 (A) that exclusively employs the vendor drug  
23 program formulary and preserves the state's ability to reduce  
24 waste, fraud, and abuse under the Medicaid program;

25 (B) that adheres to the applicable preferred drug  
26 list adopted by the commission under Section [531.072](#);

27 (C) that includes the prior authorization

1 procedures and requirements prescribed by or implemented under  
2 Sections 531.073(b), (c), and (g) for the vendor drug program;

3 (D) for purposes of which the managed care  
4 organization:

5 (i) may not negotiate or collect rebates  
6 associated with pharmacy products on the vendor drug program  
7 formulary; and

8 (ii) may not receive drug rebate or pricing  
9 information that is confidential under Section 531.071;

10 (E) that complies with the prohibition under  
11 Section 531.089;

12 (F) under which the managed care organization may  
13 not prohibit, limit, or interfere with a recipient's selection of a  
14 pharmacy or pharmacist of the recipient's choice for the provision  
15 of pharmaceutical services under the plan through the imposition of  
16 different copayments;

17 (G) that allows the managed care organization or  
18 any subcontracted pharmacy benefit manager to contract with a  
19 pharmacist or pharmacy providers separately for specialty pharmacy  
20 services, except that:

21 (i) the managed care organization and  
22 pharmacy benefit manager are prohibited from allowing exclusive  
23 contracts with a specialty pharmacy owned wholly or partly by the  
24 pharmacy benefit manager responsible for the administration of the  
25 pharmacy benefit program; and

26 (ii) the managed care organization and  
27 pharmacy benefit manager must adopt policies and procedures for

1 reclassifying prescription drugs from retail to specialty drugs,  
2 and those policies and procedures must be consistent with rules  
3 adopted by the executive commissioner and include notice to network  
4 pharmacy providers from the managed care organization;

5 (H) under which the managed care organization may  
6 not prevent a pharmacy or pharmacist from participating as a  
7 provider if the pharmacy or pharmacist agrees to comply with the  
8 financial terms and conditions of the contract as well as other  
9 reasonable administrative and professional terms and conditions of  
10 the contract;

11 (I) under which the managed care organization may  
12 include mail-order pharmacies in its networks, but may not require  
13 enrolled recipients to use those pharmacies, and may not charge an  
14 enrolled recipient who opts to use this service a fee, including  
15 postage and handling fees; and

16 (J) under which the managed care organization or  
17 pharmacy benefit manager, as applicable, must pay claims and allow  
18 the electronic submission of claims documentation in accordance  
19 with Subdivisions (7) and (7-a) [Section 843.339, Insurance Code];  
20 and

21 (24) a requirement that the managed care organization  
22 and any entity with which the managed care organization contracts  
23 for the performance of services under a managed care plan disclose,  
24 at no cost, to the commission and, on request, the office of the  
25 attorney general all discounts, incentives, rebates, fees, free  
26 goods, bundling arrangements, and other agreements affecting the  
27 net cost of goods or services provided under the plan.



1           SECTION 2. (a) The Health and Human Services Commission, in  
2 a contract between the commission and a managed care organization  
3 under Chapter 533, Government Code, that is entered into or renewed  
4 on or after the effective date of this Act, shall require that the  
5 managed care organization comply with Sections 533.005(a)(7) and  
6 (23)(J), Government Code, as amended by this Act, and Section  
7 533.005(a)(7-a), Government Code, as added by this Act.

8           (b) The Health and Human Services Commission shall seek to  
9 amend contracts entered into with managed care organizations under  
10 Chapter 533, Government Code, before the effective date of this Act  
11 to require that those managed care organizations comply with  
12 Sections 533.005(a)(7) and (23)(J), Government Code, as amended by  
13 this Act, and Section 533.005(a)(7-a), Government Code, as added by  
14 this Act. To the extent of a conflict between that section and a  
15 provision of a contract with a managed care organization entered  
16 into before the effective date of this Act, the contract provision  
17 prevails.

18           SECTION 3. If before implementing any provision of this Act  
19 a state agency determines that a waiver or authorization from a  
20 federal agency is necessary for implementation of that provision,  
21 the agency affected by the provision shall request the waiver or  
22 authorization and may delay implementing that provision until the  
23 waiver or authorization is granted.

24           SECTION 4. This Act takes effect September 1, 2015.