

By: Schwertner, et al.

S.B. No. 760

A BILL TO BE ENTITLED

AN ACT

relating to provider access and assignment requirements for a Medicaid managed care organization.

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

SECTION 1. Section 533.005(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, 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

1 training, and grievance procedures;

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

6 (6) procedures for recipient outreach and education;

7 (7) a requirement that the managed care organization
8 make payment to a physician or provider for health care services
9 rendered to a recipient under a managed care plan on any claim for
10 payment that is received with documentation reasonably necessary
11 for the managed care organization to process the claim:

12 (A) not later than:

13 (i) the 10th day after the date the claim is
14 received if the claim relates to services provided by a nursing
15 facility, intermediate care facility, or group home;

16 (ii) the 30th day after the date the claim
17 is received if the claim relates to the provision of long-term
18 services and supports not subject to Subparagraph (i); and

19 (iii) the 45th day after the date the claim
20 is received if the claim is not subject to Subparagraph (i) or (ii);
21 or

22 (B) within a period, not to exceed 60 days,
23 specified by a written agreement between the physician or provider
24 and the managed care organization;

25 (7-a) a requirement that the managed care organization
26 demonstrate to the commission that the organization pays claims
27 described by Subdivision (7)(A)(ii) on average not later than the

1 21st day after the date the claim is received by the organization;

2 (8) a requirement that the commission, on the date of a
3 recipient's enrollment in a managed care plan issued by the managed
4 care organization, inform the organization of the recipient's
5 Medicaid certification date;

6 (9) a requirement that the managed care organization
7 comply with Section 533.006 as a condition of contract retention
8 and renewal;

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

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

18 (12) if the commission finds that a managed care
19 organization has violated Subdivision (11), a requirement that the
20 managed care organization reimburse an out-of-network provider for
21 health care services at a rate that is equal to the allowable rate
22 for those services, as determined under Sections 32.028 and
23 32.0281, Human Resources Code;

24 (13) a requirement that, notwithstanding any other
25 law, including Sections 843.312 and 1301.052, Insurance Code, the
26 organization:

27 (A) use advanced practice registered nurses and

1 physician assistants in addition to physicians as primary care
2 providers to increase the availability of primary care providers in
3 the organization's provider network; and

4 (B) treat advanced practice registered nurses
5 and physician assistants in the same manner as primary care
6 physicians with regard to:

7 (i) selection and assignment as primary
8 care providers;

9 (ii) inclusion as primary care providers in
10 the organization's provider network; and

11 (iii) inclusion as primary care providers
12 in any provider network directory maintained by the organization;

13 (14) a requirement that the managed care organization
14 reimburse a federally qualified health center or rural health
15 clinic for health care services provided to a recipient outside of
16 regular business hours, including on a weekend day or holiday, at a
17 rate that is equal to the allowable rate for those services as
18 determined under Section [32.028](#), Human Resources Code, if the
19 recipient does not have a referral from the recipient's primary
20 care physician;

21 (15) a requirement that the managed care organization
22 develop, implement, and maintain a system for tracking and
23 resolving all provider appeals related to claims payment, including
24 a process that will require:

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

27 (B) the contracting with physicians who are not

1 network providers and who are of the same or related specialty as
2 the appealing physician to resolve claims disputes related to
3 denial on the basis of medical necessity that remain unresolved
4 subsequent to a provider appeal;

5 (C) the determination of the physician resolving
6 the dispute to be binding on the managed care organization and
7 provider; and

8 (D) the managed care organization to allow a
9 provider with a claim that has not been paid before the time
10 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
11 claim;

12 (16) a requirement that a medical director who is
13 authorized to make medical necessity determinations is available to
14 the region where the managed care organization provides health care
15 services;

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

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

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

27 (20) a requirement that the managed care organization:

1 (A) develop and submit to the commission, before
2 the organization begins to provide health care services to
3 recipients, a comprehensive plan that describes how the
4 organization's provider network complies with the provider access
5 standards established under Section 533.0061 [~~will provide~~
6 ~~recipients sufficient access to:~~

- 7 [(i) ~~preventive care;~~
- 8 [(ii) ~~primary care;~~
- 9 [(iii) ~~specialty care;~~
- 10 [(iv) ~~after-hours urgent care;~~
- 11 [(v) ~~chronic care;~~
- 12 [(vi) ~~long-term services and supports;~~
- 13 [(vii) ~~nursing services; and~~
- 14 [(viii) ~~therapy services, including~~
15 ~~services provided in a clinical setting or in a home or~~
16 ~~community-based setting]; [and]~~

17 (B) as a condition of contract retention and
18 renewal:

19 (i) continue to comply with the provider
20 access standards established under Section 533.0061; and

21 (ii) make substantial efforts, as
22 determined by the commission, to mitigate or remedy any
23 noncompliance with the provider access standards established under
24 Section 533.0061;

25 (C) pay liquidated damages for each failure, as
26 determined by the commission, to comply with the provider access
27 standards established under Section 533.0061 in amounts that are

1 reasonably related to the noncompliance; and

2 (D) regularly, as determined by the commission,
3 submit to the commission and make available to the public a report
4 containing data on the sufficiency of the organization's provider
5 network with regard to providing the care and services described
6 under Section 533.0061(a) [~~Paragraph (A)~~] and specific data with
7 respect to access to primary care, specialty care, long-term
8 services and supports, nursing services, and therapy services
9 [~~Paragraphs (A)(iii), (vi), (vii), and (viii)~~] on the average
10 length of time between:

11 (i) the date a provider requests prior
12 authorization [~~makes a referral~~] for the care or service and the
13 date the organization approves or denies the request [~~referral~~];
14 and

15 (ii) the date the organization approves a
16 request for prior authorization [~~referral~~] for the care or service
17 and the date the care or service is initiated;

18 (21) a requirement that the managed care organization
19 demonstrate to the commission, before the organization begins to
20 provide health care services to recipients, that, subject to the
21 provider access standards established under Section 533.0061:

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

25 (B) the organization's provider network
26 includes:

27 (i) a sufficient number of primary care

1 providers;

2 (ii) a sufficient variety of provider
3 types;

4 (iii) a sufficient number of providers of
5 long-term services and supports and specialty pediatric care
6 providers of home and community-based services; and

7 (iv) providers located throughout the
8 region where the organization will provide health care services;
9 and

10 (C) health care services will be accessible to
11 recipients through the organization's provider network to a
12 comparable extent that health care services would be available to
13 recipients under a fee-for-service or primary care case management
14 model of Medicaid managed care;

15 (22) a requirement that the managed care organization
16 develop a monitoring program for measuring the quality of the
17 health care services provided by the organization's provider
18 network that:

19 (A) incorporates the National Committee for
20 Quality Assurance's Healthcare Effectiveness Data and Information
21 Set (HEDIS) measures;

22 (B) focuses on measuring outcomes; and

23 (C) includes the collection and analysis of
24 clinical data relating to prenatal care, preventive care, mental
25 health care, and the treatment of acute and chronic health
26 conditions and substance abuse;

27 (23) subject to Subsection (a-1), a requirement that

1 the managed care organization develop, implement, and maintain an
2 outpatient pharmacy benefit plan for its enrolled recipients:

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

6 (B) that adheres to the applicable preferred drug
7 list adopted by the commission under Section 531.072;

8 (C) that includes the prior authorization
9 procedures and requirements prescribed by or implemented under
10 Sections 531.073(b), (c), and (g) for the vendor drug program;

11 (D) for purposes of which the managed care
12 organization:

13 (i) may not negotiate or collect rebates
14 associated with pharmacy products on the vendor drug program
15 formulary; and

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

18 (E) that complies with the prohibition under
19 Section 531.089;

20 (F) under which the managed care organization may
21 not prohibit, limit, or interfere with a recipient's selection of a
22 pharmacy or pharmacist of the recipient's choice for the provision
23 of pharmaceutical services under the plan through the imposition of
24 different copayments;

25 (G) that allows the managed care organization or
26 any subcontracted pharmacy benefit manager to contract with a
27 pharmacist or pharmacy providers separately for specialty pharmacy

1 services, except that:

2 (i) the managed care organization and
3 pharmacy benefit manager are prohibited from allowing exclusive
4 contracts with a specialty pharmacy owned wholly or partly by the
5 pharmacy benefit manager responsible for the administration of the
6 pharmacy benefit program; and

7 (ii) the managed care organization and
8 pharmacy benefit manager must adopt policies and procedures for
9 reclassifying prescription drugs from retail to specialty drugs,
10 and those policies and procedures must be consistent with rules
11 adopted by the executive commissioner and include notice to network
12 pharmacy providers from the managed care organization;

13 (H) under which the managed care organization may
14 not prevent a pharmacy or pharmacist from participating as a
15 provider if the pharmacy or pharmacist agrees to comply with the
16 financial terms and conditions of the contract as well as other
17 reasonable administrative and professional terms and conditions of
18 the contract;

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

24 (J) under which the managed care organization or
25 pharmacy benefit manager, as applicable, must pay claims in
26 accordance with Section [843.339](#), Insurance Code; and

27 (K) under which the managed care organization or

1 pharmacy benefit manager, as applicable:

2 (i) to place a drug on a maximum allowable
3 cost list, must ensure that:

4 (a) the drug is listed as "A" or "B"
5 rated in the most recent version of the United States Food and Drug
6 Administration's Approved Drug Products with Therapeutic
7 Equivalence Evaluations, also known as the Orange Book, has an "NR"
8 or "NA" rating or a similar rating by a nationally recognized
9 reference; and

10 (b) the drug is generally available
11 for purchase by pharmacies in the state from national or regional
12 wholesalers and is not obsolete;

13 (ii) must provide to a network pharmacy
14 provider, at the time a contract is entered into or renewed with the
15 network pharmacy provider, the sources used to determine the
16 maximum allowable cost pricing for the maximum allowable cost list
17 specific to that provider;

18 (iii) must review and update maximum
19 allowable cost price information at least once every seven days to
20 reflect any modification of maximum allowable cost pricing;

21 (iv) must, in formulating the maximum
22 allowable cost price for a drug, use only the price of the drug and
23 drugs listed as therapeutically equivalent in the most recent
24 version of the United States Food and Drug Administration's
25 Approved Drug Products with Therapeutic Equivalence Evaluations,
26 also known as the Orange Book;

27 (v) must establish a process for

1 eliminating products from the maximum allowable cost list or
2 modifying maximum allowable cost prices in a timely manner to
3 remain consistent with pricing changes and product availability in
4 the marketplace;

5 (vi) must:

6 (a) provide a procedure under which a
7 network pharmacy provider may challenge a listed maximum allowable
8 cost price for a drug;

9 (b) respond to a challenge not later
10 than the 15th day after the date the challenge is made;

11 (c) if the challenge is successful,
12 make an adjustment in the drug price effective on the date the
13 challenge is resolved, and make the adjustment applicable to all
14 similarly situated network pharmacy providers, as determined by the
15 managed care organization or pharmacy benefit manager, as
16 appropriate;

17 (d) if the challenge is denied,
18 provide the reason for the denial; and

19 (e) report to the commission every 90
20 days the total number of challenges that were made and denied in the
21 preceding 90-day period for each maximum allowable cost list drug
22 for which a challenge was denied during the period;

23 (vii) must notify the commission not later
24 than the 21st day after implementing a practice of using a maximum
25 allowable cost list for drugs dispensed at retail but not by mail;
26 and

27 (viii) must provide a process for each of

1 its network pharmacy providers to readily access the maximum
2 allowable cost list specific to that provider;

3 (24) a requirement that the managed care organization
4 and any entity with which the managed care organization contracts
5 for the performance of services under a managed care plan disclose,
6 at no cost, to the commission and, on request, the office of the
7 attorney general all discounts, incentives, rebates, fees, free
8 goods, bundling arrangements, and other agreements affecting the
9 net cost of goods or services provided under the plan; ~~and~~

10 (25) a requirement that the managed care organization
11 not implement significant, nonnegotiated, across-the-board
12 provider reimbursement rate reductions unless:

13 (A) subject to Subsection (a-3), the
14 organization has the prior approval of the commission to make the
15 reduction; or

16 (B) the rate reductions are based on changes to
17 the Medicaid fee schedule or cost containment initiatives
18 implemented by the commission; and

19 (26) a requirement that the managed care organization
20 make initial and subsequent primary care provider assignments and
21 changes.

22 SECTION 2. Subchapter A, Chapter 533, Government Code, is
23 amended by adding Sections 533.0061, 533.0062, 533.0063, and
24 533.0064 to read as follows:

25 Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) The
26 commission shall establish minimum provider access standards for
27 the provider network of a managed care organization that contracts

1 with the commission to provide health care services to recipients.

2 The access standards must ensure that a managed care organization

3 provides recipients sufficient access to:

4 (1) preventive care;

5 (2) primary care;

6 (3) specialty care;

7 (4) after-hours urgent care;

8 (5) chronic care;

9 (6) long-term services and supports;

10 (7) nursing services;

11 (8) therapy services, including services provided in a

12 clinical setting or in a home or community-based setting; and

13 (9) any other services identified by the commission.

14 (b) To the extent it is feasible, the provider access

15 standards established under this section must:

16 (1) distinguish between access to providers in urban

17 and rural settings; and

18 (2) consider the number and geographic distribution of

19 Medicaid-enrolled providers in a particular service delivery area.

20 (c) The commission shall biennially submit to the

21 legislature and make available to the public a report containing

22 information and statistics about recipient access to providers

23 through the provider networks of the managed care organizations and

24 managed care organization compliance with contractual obligations

25 related to provider access standards established under this

26 section. The report must contain:

27 (1) a compilation and analysis of information

1 submitted to the commission under Section 533.005(a)(20)(D);

2 (2) for both primary care providers and specialty
3 providers, information on provider-to-recipient ratios in an
4 organization's provider network, as well as benchmark ratios to
5 indicate whether deficiencies exist in a given network; and

6 (3) a description of, and analysis of the results
7 from, the commission's monitoring process established under
8 Section 533.007(1).

9 Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO
10 COMPLY WITH PROVIDER ACCESS STANDARDS. If a managed care
11 organization that has contracted with the commission to provide
12 health care services to recipients fails to comply with one or more
13 provider access standards established under Section 533.0061 and
14 the commission determines the organization has not made substantial
15 efforts to mitigate or remedy the noncompliance, the commission:

16 (1) may:

17 (A) elect to not retain or renew the commission's
18 contract with the organization; or

19 (B) require the organization to pay liquidated
20 damages in accordance with Section 533.005(a)(20)(C); and

21 (2) shall suspend default enrollment to the
22 organization in a given service delivery area for at least one
23 calendar quarter if the organization's noncompliance occurs in the
24 service delivery area for two consecutive calendar quarters.

25 Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) The
26 commission shall ensure that a managed care organization that
27 contracts with the commission to provide health care services to

1 recipients:

2 (1) posts on the organization's Internet website:

3 (A) the organization's provider network
4 directory; and

5 (B) a direct telephone number and e-mail address
6 through which a recipient enrolled in the organization's managed
7 care plan or the recipient's provider may contact the organization
8 to receive assistance with:

9 (i) identifying in-network providers and
10 services available to the recipient; and

11 (ii) scheduling an appointment for the
12 recipient with an available in-network provider or to access
13 available in-network services; and

14 (2) updates the online directory required under
15 Subdivision (1)(A) at least monthly.

16 (b) Except as provided by Subsection (c), a managed care
17 organization is required to send a paper form of the organization's
18 provider network directory for the program only to a recipient who
19 requests to receive the directory in paper form.

20 (c) A managed care organization participating in the STAR +
21 PLUS Medicaid managed care program or STAR Kids Medicaid managed
22 care program established under Section 533.00253 shall, for a
23 recipient in that program, issue a provider network directory for
24 the program in paper form unless the recipient opts out of receiving
25 the directory in paper form.

26 Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN
27 PROVIDERS. (a) In this section, "applicant provider" means a

1 physician or other health care provider applying for expedited
2 credentialing under this section.

3 (b) Notwithstanding any other law and subject to Subsection
4 (c), a managed care organization that contracts with the commission
5 to provide health services to recipients shall, in accordance with
6 this section, establish and implement an expedited credentialing
7 process that would allow applicant providers to provide services to
8 recipients on a provisional basis.

9 (c) The commission shall identify the types of providers for
10 which an expedited credentialing process must be established and
11 implemented under this section.

12 (d) To qualify for expedited credentialing under this
13 section and payment under Subsection (e), an applicant provider
14 must:

15 (1) be a member of an established health care provider
16 group that has a current contract in force with a managed care
17 organization described by Subsection (b);

18 (2) be a Medicaid-enrolled provider;

19 (3) agree to comply with the terms of the contract
20 described by Subdivision (1); and

21 (4) submit all documentation and other information
22 required by the managed care organization as necessary to enable
23 the organization to begin the credentialing process required by the
24 organization to include a provider in the organization's provider
25 network.

26 (e) On submission by the applicant provider of the
27 information required by the managed care organization under

1 Subsection (d), and for Medicaid reimbursement purposes only, the
2 organization shall treat the provider as if the provider were in the
3 organization's provider network when the provider provides
4 services to recipients, subject to Subsections (f) and (g).

5 (f) Except as provided by Subsection (g), if, on completion
6 of the credentialing process, a managed care organization
7 determines that the applicant provider does not meet the
8 organization's credentialing requirements, the organization may
9 recover from the provider the difference between payments for
10 in-network benefits and out-of-network benefits.

11 (g) If a managed care organization determines on completion
12 of the credentialing process that the applicant provider does not
13 meet the organization's credentialing requirements and that the
14 provider made fraudulent claims in the provider's application for
15 credentialing, the organization may recover from the provider the
16 entire amount of any payment paid to the provider.

17 SECTION 3. Section 533.007, Government Code, is amended by
18 adding Subsection (1) to read as follows:

19 (1) The commission shall establish and implement a process
20 for the direct monitoring of a managed care organization's provider
21 network and providers in the network. The process:

22 (1) must be used to ensure compliance with contractual
23 obligations related to:

24 (A) the number of providers accepting new
25 patients under the Medicaid managed care program; and

26 (B) the length of time a recipient must wait
27 between scheduling an appointment with a provider and receiving

1 treatment from the provider;

2 (2) may use reasonable methods to ensure compliance
3 with contractual obligations, including telephone calls made at
4 random times without notice to assess the availability of providers
5 and services to new and existing recipients; and

6 (3) may be implemented directly by the commission or
7 through a contractor.

8 SECTION 4. (a) The Health and Human Services Commission,
9 in a contract between the commission and a managed care
10 organization under Chapter 533, Government Code, that is entered
11 into or renewed on or after the effective date of this Act, shall
12 require that the managed care organization comply with:

13 (1) Section 533.005(a), Government Code, as amended by
14 this Act;

15 (2) the standards established under Section
16 533.0061(a), Government Code, as added by this Act; and

17 (3) Section 533.0063, Government Code, as added by
18 this Act.

19 (b) The Health and Human Services Commission shall seek to
20 amend contracts entered into with managed care organizations under
21 Chapter 533, Government Code, before the effective date of this Act
22 to require that those managed care organizations comply with the
23 provisions specified in Subsection (a) of this section. To the
24 extent of a conflict between those provisions and a provision of a
25 contract with a managed care organization entered into before the
26 effective date of this Act, the contract provision prevails.

27 SECTION 5. The Health and Human Services Commission shall

1 submit to the legislature the initial report required under Section
2 533.0061(c), Government Code, as added by this Act, not later than
3 December 1, 2016.

4 SECTION 6. If before implementing any provision of this Act
5 a state agency determines that a waiver or authorization from a
6 federal agency is necessary for implementation of that provision,
7 the agency affected by the provision shall request the waiver or
8 authorization and may delay implementing that provision until the
9 waiver or authorization is granted.

10 SECTION 7. This Act takes effect September 1, 2015.